Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Alisea 01:00 km Lawrence January Z . 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University of Baltimore City Maryland Medical System If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 03 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Min. Months Days Hours 1**∑** M 2□ F MD 69 Director 213-32-7198 Usual Residence of Decedent 10b. County 10d, Inside City Limits 10a, State 10c. City. Town or Location or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21122 771 203rd Street or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: if Item 27 Is marked other then " Elementary/Secondary (0-12) Cottege (1-4or 5+) Health Care Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Η. Alisea White Lawrence Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5312 Patrick Henry Drive, Brooklyn Park, MD 21225 Sharon Alisea (daughter) 80° 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Depertment of Importent: if eny injury or once. 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc Baltimore, Maryland 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only on ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive heart Physician tailure disease or condition resulting in death) /Medical Due to (or as a consequence of): unclear Examiner disease Coronary artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9☐ Unknown 9 Unknown ģ bete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 1 No 1 Yes 2 ₽No 1 TYes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient Certification: To 1 Tes 2₽No 2 ER/Outpatient 3 DOA his. After this funeral d 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending efter death.
I Director: Aft 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 MD. January 2. 2007 AU417643541666 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21201 5+. 3IK South M.D 27 Greene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day

32 Aegistrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Rea. No. Reg. No. 2. Date of Death 3. Time of Death Month Year Physician 16 2007 /Medical 4c. County of Death 4b. City Town, of Location of Death et institution, give street and number) Examiner Security Number 6. Sex Year Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days 18.78-1245 Months Hours 1 ☐ M 2 🔀 F NC 05.07. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore 1 Ves 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Kavenwood Alenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (14or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Weldon 2 vanc 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, EVelyn Anderson
20a. Method of Disposition Ravenwood Avenue Balto. SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/12/07 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Greenmount oremations: 21. Signature of Funeral Service Licensee C. Giveni Funeral Sewice M0212/2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between One t and leath Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 24 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed by t t be detach Part II. Oth significant conditions of outing to deat | but | at resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s certificate 212 No 1∐ Yes Division or Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Mann eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certified (Nem 23a) (Type Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 0 5

			For State Registrar	State of Marylan	-	rtment of F			Reg. No.	2007	00003
	Physici		1. Decedent's Name (First, Middle, Last) $Josephine$	Elizabeth	A1-	Greene		2. Date of Da. Month	Day	2067	3. Time of Death
	/Medic Examin			lare Hosp		Ros	r Location of Death Sedale		E	ounty of Death	nure
	Funeral Director		5. Social Security Number 178-16-9472 Usual Residence of Decedent	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July2,	1 921	Phi	place (State or Foreign http:// adelphia
	death with the Maryland rms 23a or 28a-f ehow	or	10a. State 10b. County N.J. n/a		y, Town or Loc Ocean (1	0d. Inside City Limits 1 X Yes 2 No
2)	or 28a-	Olrect	10e. Sireet and Number			10f. Zip Code			•	en of What Cour	ntry?
76	after death with or Items 23a or	eral	924 Central Ave	enue 12. Was Decedent Ever in U	I.S. 13 W	0822		ecify Yes or No		S.A.	ean Indian,
asephine	or Ite	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 1 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify: Wh	etc. nite
JOSEP 121215-0036	n 72	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give k		pation during most of work d)	ing		of Business/In Home	dustry
קי ל	e filed vil Hygie other i	e Co	12th 17. Father's Name (First, Middle, Last)	2	ноше	Maker	18. Mother's Name	e (First, Middle			
F718	should be ind Mental I marked o	To Be	John Heinz				Joseph	ine A.	Sch	nneide	•
AI-greene, Baltimore, Maryland	d2 th a		19a. Informant's Name/Relationship (Ty Beverley Al-Gre				and Number or Rur Mill C				n,Md21236
ge,	permit. Pages 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. F		ition (Name of atory or other place		Date		ation - City or To	
Time time	t. Pag rtment rtent: I		4 ☐ Donation 5 ☐ Other (Specify)	Res							PA.19020 L Home, PA
Bal	permit. Depertr Importe any Inje		21. Signature of Funeral Service Licens Tourt	Inly			dalk Ave				
	Pnysician:		23a. Part1. Enter the disease, &r compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line.	th. Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulling in death)	Due to (or as a conseq	quence of):						
	Si The Bd	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juence of:						
8760,	ate be executed hysicien end the burial-transit	Examiner	that initiated events ' c. resulting in death) Last								
6876	ficate b physic s the b	edical		d							
P.O. Box (Attending Physician: The law requires that the death certificate be executed reath.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, oulcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of conditions of the co	aldeath 3 □l	Ectopic pregnancy Other (specify)	у		2:	3d. Date of deliv Month	ery Day Year
	uires that t signed by id be detac	þ	Part II. Other significant conditions co.	ntributing to death but not res	sulting in the un	derlying cause giv	ven in Part I.	23e. Did 1		/	he cause of death?
cor	aw requir is been si 2 should	Completed						24a. Was		24b. Were auto	ppsy lindings available
E P	: The lav	Com						auto perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	mpletion of cause of 2. No
Vite	sician: certifice irector, p	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ▼	ER/Outpatient	all pos Ott	26. Place of Deal			☐Other (Speci	4.1
n of	ding Phys h. After this funeral di	on; To	27. Magner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	3☐ DOA 28c. Injui	The state of the s	28d. Describe			ny)
Division of Vital Records,	or Attendii ifter death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, larm, stre	M 1]Yes 2 □ No —		Street and wn, State)	Number or Rur	al Route Number,
	Hospital 4 hours e Funeral (ledical Ce	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kniner: On the basis of examina	owledge, death ation and/or inv	occurred at the tilestigation, in my o	me, date and place, opinion, death occur	and due to the	cause(s) a	and manner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	. 2. 0		of U. U	IX. D.	0.	H00	64433		Fin	116/1	1,2007
	3	150	me and are ess of person who co	ompleted cause of death (Ite	m 23a) (Type,	1000 Fr	anklin Si	mare -	Driv	e pal	t. MD. 21237
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sign		- F	** ** * * * * *	t-	7 1 1	- DOT	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1

			Please I	State of Maryland				-	_	10000	
			1 - For State Registrar	State of Maryland		icate of l			2001	00004	
			Decedent's Name (First, Middle, Last)					2. Date of Dea	eg. No. th	3. Time of Death	
	Physici		DOROTHY AV	nend				Month	Day Year	- 1 7 9 - 1114	
	/Medio Examin		4a. Facility Name (If not institution, give s		4b	o. City, Town, or	Location of Death		4c. County of De		
	Ladiiii		Bayview Hospital		1	Baltimo	re		n/a		
	Funeral		5. Social Security Number 6. Sex	M 20 F	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year) 9. B	irthplace (State or Foreign Country)	
	Director		217-16-7470 Usual Residence of Decedent	86	Yrs.			July 6		ryland	
	and wand		10a. State 10b. County	10c. City, T	own or Location	on		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits	
	Many Hear	ţ	MD n/a	Ra1	timore					1 X Yes 2 ☐ No	
	th the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?	
	23a c	Funeral Director	628 South Grundy	Street	2	21224			U.S.A.		
	r dea	ne	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hiss, specify Cuba	ispanic Origin? (S an, Mexican, Puert	14. Race - An Black, Wh	nerican Indian, nite, etc.		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔂 No If Yes, Give			Specify:		Specify: [White	
21215-0036	ture!	ed b	15. Decedent's Educ	Year or Dates:	16a Decedent	's Usual Occupa	ation		16b. Kind of Busines	s/Industry	
715	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or items 23a or 28a-f show event, ite Medicul Examination must be notified at	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind life. DO l	d of work done o NOT use retired	during most of wor 1)	king		,	
212	iould be filed withing the Mental Hygiene. Parked other then talle event, Ille Mental	Completed	6th grade		Housew	ife			Own Home		
pu	at Hygid t other	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, i	Maiden Surname)		
yla	2 should be filed v and Mental Hygie 1s marked other reumatic event, !!!	2	John Devine					ce Burke	rke		
Maryland	and and ls n		19a. Informant's Name/Relationship (Type Martha Jane Ailif	·	-				r, City or Town, State Maryland	Zip Code) 21224	
	1 and Health em 27 ther t		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	e of Dispositio		Teel, Da.		20c. Location - City		
Baltimore,	t. Pager rtment o rtant; If		1 □ Burial 2 □ Cremation 3 □ R	emoval from State	etery, cremato	ory or other plac	1				
Ē			21. Signature of Funeral Service License		1111111111	emetery			Baltimore innel Fune	eral Home, Inc	
Ba	Depa Impo any ir		1 A tors						re, Maryla		
			23a. Part1. Enter the disease or complications of heart failure. List only on	ations that caused the death. [Do not enter th	ne mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		Onset and Death						
	/Medical		resulting in death)	Due to (or as a consequen		leme	01				
п	Examiner	L	Sequentially list conditions, b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):						
	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequen	nce of):						
760,	te be executed ysician and e burial-transit	cal E									
89	death certificate b attending physic										
Вох	th cert endin	M/us	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal de		opic pregnancy			23d. Date of d		
	s deat he att ed for	sicis	in the past 12 months? 1 □ Yes 2 ➡No	4☐Pregnant at time of death		her (specify)		 	Month	Day Year	
P.O	The law requires that the death certifical tile has been signed by the attending phyage 2 should be delached for use as the	Physician/Medi	9 Unknown		:			22a Didas		to the cause of death?	
JS,	uires tha signed	b	Part II. Other significant conditions con	1	to de	riving cause give	en in Part I.	4		Probably 4 Unknown	
Records,	w requ	Completed by	800			~ 70	<u> </u>	-			
Rec	The law	mpi	Tugranence					24a. Was a autops perfor	y prior to	autopsy findings available completion of cause of	
B		e Co	25. Was case referred to medical				00.01 4.0	1 ☐ Yes	A	es 2□No	
Vital	00	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3	3□ DOA Othe	00	th (Check only on	ence 6 ⊡Other (Sp	naciful	
of			27. Manner of Death		b. Time of	28c. Injury	y at		ow injury occurred	ochy)	
jor	ath. r: After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Tear)	Injury	M 1 🗆	Yes 2 □ No				
Division	after death. after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street,	factory, office		28f. Location (Si City or Town	treet and Number or in, State)	Aural Route Number,	
Ω	the Hospitel or Attending nin 24 hours after death. the Funerel Director: After npletely filled in by the fune										
	Hosp 24 hou Fune Fune tely fi	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physical Exemination (Check only one)	icien: To the best of my knowle er: On the basis of examination	edge, death oc n and/or investi	curred at the timi igation, in my op	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	2	9d. Date signed (Mo	nth, Day, Year)	
)	× 3 + 8		Deres a. C.	retto m		035	763	0	MALLEN S	32007	
ጎ	1		30. Name and address of person who co	npleted cause of death (Item 23	Ba) (Type, Prin	11)	^	. 2	mary :	1 400 /	
de			Grace A. Cords M	0 500-11	Kins	Bay vi	ew Cir	cle B	altimore	1 / 21224	
	Sta		31. Date filed (Month, Day, Year)	32. Ri gištrar's Signature		20 0		i			
	Registr	ar	JAN 0 5 20	11/ 1 1200 - 1	S PAR	263 9					

			1 - For State Registrar	State of Marylan		artment of F rtificate of			ene 007	00006			
	Physici /Medic		1. Decedent's Name (First, Middle, Las Paul Brez	ler				2. Date of Death Month January	05 2007°				
	Examin	er	4a. Facility Name (If not institution, given 254 Carroll Road				r Location of Deat Sadena	h	4c. County of Dea				
Ī	Funeral Director		5. Social Security Number 6. S 214-48-2001 1	ex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	9. Bi	rthplace (State or Foreign country)			
Maryland	-f ehow lind at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		y, Town or Lo		ısadena			10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
t t	a or 28a Lbe poti	1 Direc	10e. Street and Number 254 Carroll Road			10f. Zip Code	21122	10	g. Citizen of What C	country?			
U K I K I 3-0030	f Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be motified at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Specify Yes or No- to Rican, etc.)	14. Race - Am Bfack, Wh						
0-C121	ne. than "natur e Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	rking 1	16b. Kind of Business/Industry				
aryiding 6	fental Hygiene. rked other than tic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Thomas L.	Brezler Sr.		Plumber	18. Mother's Na		C & H Mechanical (First, Middle, Maiden Sumame) a E. Perry				
i, IMary	Heelth and M tem 27 is mar other traumat	19a. Informant's Name/Relationship (Type, Print) Edith A. Brezler (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, C. 254 Carroll Road, Pasadena, MD											
Dallillore	Department of Heel important: if item 2 any injury or other once.		20a. Method of Disposition 1 Serial 2 Cremation 3 4 Donation 5 Other (Specification) 21. Signature of Juneral Service Light	Removal from State	Place of Dispo emetery, crer en Have	esition (Name of matory or other pla en Cemete 2. Name and Addre	ery Jan ess of Facility	. 09 007 G Stallin	loc. Location - City o 1en Burni	e, Maryland 1 Home, P.A.			
	hysician /Medical xaminer		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	or cause of each line.	E 2 uence of):	er the mode of dyi		c or respiratory arre		Approximate Interval Between Onset and Death Two YEAR			
law requires that the death cartificate he executed	by the ettending physicien and tached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
.O. box	by the ettending ached for use	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	Ideath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of do Month	elivery Day Year			
ords, r	been signed beshould be det	Ď	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.			to the cause of death? Probably 4 Unknown			
E 2	page	e Completed	25. Was case referred to medical				C. Place of Do	24a. Was an autopsy perform	prior to death? No 1 □ Ye	autopsy findings available completion of cause of			
	his cer I direct	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Ott	ner: 4 🗆 Nursing I	ath Check only one	nce 6 □Other (Sp	ecify)			
JIVISION OI VIIA	or death. •ctor: After this certifical by the funeral director, p	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e Co Blood (1)	28b. Time of Injury	f 28c. Inju Wo M 1	ryat rk? Yes 2 □ No	28d. Describe ho	w injury occurred	Rural Route Number,			
VIU	# 		4 Homicide determined 29a. Certifier 1X Certifying Pt	building, etc. (Specify	y)	h odeured at the fi	mu datu and plac	City or Town,	State)	os status			
To the Ho	within 24 t To the Fu completely	Medical	(Check only one) 2 Medical Example of Control of Contr	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	opinion, death occ	urred at the time, da	te and place, and du	ue to the cause(s)			
	٨		30. Name and address of person who			Print)		6	1/5/0	7			
	Sta Registr		ROBERTO PILI 31. Date filed (Month, Day, Year)	JOHN S HOF		HOSPITA	4011	BROTE	NIEW B.	ALTIMORE MIN			

07-00007	
Willie L. Brown	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yiand / Department of Freath and Wentai Free State Registrar		9 No. 200	7 0000
Physici ledical Exam	an/	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death 0900 hrs
are Livering	ille.	WILLIE L. BROWN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	January 1,	4c County of Death	
		401 E. 25th Street Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	(MM/DD/YYYY) 9 Birt Foreig	hplace (State or
Director		247-98-0348 1K M 2 F 53 Yrs.	07/31/	1953 Co	n SOUTH CAROLINA
any		Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10c. City, Town or Location			10d Inside City Limits
Maryland 28a-f show any d at once,	ř	MARYLAND N/A BALTIMORE			1 X Yes 2 No
Marylz 28a-f d at or	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once,		401 EAST 25th STREET APT 5C 21211		U.S.A.	
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiers is a first with the maryland; or items 23a or 28a-f she rair event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Never Married 2 Married 2 Married 2 Married 12. Was Decedent Of Hispanic Origin? (Sp. 15. Never Married 2 Married 14. Never Married 15. Never Married 16. Never Married 16. Never Married 16. Never Married 17. Never Married 17. Never Married 17. Never Married 18. Never Married 18. Never Married 18. Never Married 19. Never Married 1		14. Race - Ameri White, etc.	can Indian, Black,
ifter de il", or	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify:		Specify: BLA	CK
2 hours aft "matural" Examing		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume most of working life. DO NOT use retired to the complete of the complet		16b. Kind of Business/I	ndustry
36 in 72 han " dical I	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		unknown	
5-0036 led within 72 Hygiene other than '	L Com	11th grade unknown 17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M		
21215-0036 and be filed within 72 Mental Hygiene marked other than c event, the Medical	Be	WILLIE BROWN QUEE	NIE GIB	3S	
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I taut: If item 27 is marked or other traumatic event,	T ₀	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		•	
Baltimore, MD oernit. Pages I and 2 sh Department of Health and Important: If item 27 is njury or other traumat	1	Joan Gibbs-Jefferson/Sister 124 Butterfly Lane, 2Ca. Method of Disposition 2Cb. Place of Disposition (Name of cemetery)	Monks Co	2Cc. Location - City or	
Baltimore permit. Pages I Department of I Important: If i		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Dogetion 5 Other Specify Nazareth Cemetery 01-	06-07	PINOPOLIS,	c c
Baltin Permit. I Departm Importa	Ì	21. Signifure of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN CO	MMIINITTY		
		32 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	E, BALT	IMORE, MARYA	LND 21217
Physician /Medical		failure. List only one cause on each line.	r respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Diabetic ketoacidosis Due to (or as a consequence of):			200
	ابا	Sequentially list conditions, b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause Creepes of many that indicted		Bi Bi	
ted I Insit	Exal	events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	X UNPENDED #23a,PII,27,perME, g863, 1/11/07 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate bewinth 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.		IF FEMALE. 23c. If yes, outcome of pregnancy		23d Date of delivery	
Box 68's death certiff	Physician/	past 12 months? 2 Fetal death 3 Ectopic pregns 4 Pregnant at time of death 5 Other (Specify)	ancy	Month [Day Year
Bo ne deat the at	hys	1 Yes 2 No 9 Unknown 9 Unknown		1	
tal Records, P.O. Box 68: rian: The law requires that the death certificate certificate has been signed by the attending ector, page 2 should be detached for use as to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Narcotic use, hypertensive cardiovascular disease		pacco use contribute to	
ds, equire een sig ould be	Completed by	indeceded date, hyperconductive distribution distribution	24a. Was a		topsy findings available
e law r e has b ge 2 sh	d m		autops	med? death?	completion of cause of
al Re		25. Was case referred to medical 26.Place of Death (Check	1 Yes 2 only one)	No 1 Y	es 2 No
Division of Vital Records, rat or Attending Physician: The law require star death as a birerdent. After this certificate has been sited in by the funeral director, page 2 should b	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	ng Home 5 1	Residence 6 🗸 Other	Scene
n of		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending	28d. Describe h	ow injury occurred	
ision Atten rector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm street factory office huilding etc.	28f Location (S	treet and Number or Ru	ral Route Number City
Division of Vital Rec ours after death certal Director. After this certificate b filled in by the funeral director. page	Certification:	Suicide 6 Could not be determined (Specify)	or Town, St		rainoate Namber, only
e Hosp 24 hose e Fune etely fi		29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated	at the time, date a		
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	ntn, Day,Year)
		30 Name and address of person who completed cause of death (Item 23a)			
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	21201		
S Regis	tate	31 Date filed (Month, Day, Year) 32. Perguitrar's Signature			
DHMH 17 Rev 1/2		JAN 0 5 2007 ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Ma	arylan		artment of tificate o	Health and f Death		jiene eg. No.	00008		
	Physici /Medic		1. Decedent's Name (First, Middle, Irene Elsie Bie	ddle					2. Date of Deal Month Janua	Day Year	7 1:48 AM		
	Examir	er	4a. Facility Name (If not institution, Franklin Sq	, ware Ho	spi-	tal	4b. City, Town	or Location of Deat		4d. County of De	timore		
	Funeral Director		5. Social Security Number 212–24–8097 Usual Residence of Decedent	7. Age 1 M 2 F	85	last birthday) Yrs.	Months Day			1921 I	irthplace (State or Foreign Country) Maryland		
	ith the Maryland or 28a-f ehow	ctor	MD Balt	imore		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No		
0.1	deeth with the Maryland ms 23a or 28a-f ehow f must be notified at	ral Director	10e. Street and Number 19 Powderock 1	Place			10f. Zip Code 212		1	U.S.A.	Country?		
~ / ~ // 036	after or ite	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 M N If Yes, Give Year or Dates:		i	Nas Decedent of Yes, specify Cu 1 ☐ Yes 2X N	f Hispanic Origin? (Suban, Mexican, Puer o <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	or No- 2.) 14. Race - American Indian, Black, White, etc. Specify: White			
21215-0		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		i+)	(Give	lent's Usual Occ kind of work dor DO NOT use reti	e during most of wo	rking	16b. Kind of Busines	s/Industry		
and 2	be filed tal Hygi d other	To Be Co	12 17. Father's Name (First, Middle, L. Samuel B. Woodwa	•		Own Ho Maiden Sumame)	me						
1/6/Wary	end 2 shousalth and M		19a. Informant's Name/Relationshi	p (Type, Print)	1)			et and Number or R		r, City or Town, State			
$3i^{\circ}$	Samuel B. Woodward Samuel B. Woodward Samuel B. Woodward									, Maryland			
Ball	permit Depart Import eny in		21. So nature of Funeral Service Li	258cha		11	750 Bel	air Road	- Kingsvi	ille, Mary	l Home, P.A. land 21087		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	shock, or heart failure. List only one cause on each line. Interdiate Cause (Final disease or condition resulting in death) a. AC YE MyoCaydia Interdiate On Due to (or as a consequence of):									
,760,	ate be executed hysicien and the burial-transit	Il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to as a consequence of): c. Due to (or as a consequence of):										
P.O. Box 6870	Attanding Physician: The law requires that the death certificate i reath. setor: Atter this certificate has been signed by the ettending physis, the funeral director, page 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	ıl death 3 ☐	Ectopic pregnar	псу		23d. Date of o	lelivery Day Year		
ds, P.	uires thet the signed by id be detacted	ρ	Part II. Other significant condition	' Is contributing to death be	ut not res	ulting in the u	nderlying cause	given in Part I.	23a. Did to		to the cause of death?		
Recol	The law requires the second second the second secon	Completed							24a. Was a autop: perfor	sy prior t med? death	autopsy findings available o completion of cause of		
of Vita	ding Physician: The I h. After this certificate he funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eath	Hospital:	-	ER/Outpatier	T 3 DOA	Other: 4 Nursing I	ath Check only or	ence 6 Other (S			
Division of Vital Records,	To the Hospital or Attending within 24 hours after Seath. To the Funerel Director: After completely filled in by the funer	Certification;	1 Natural 5 Pending investige 6 Could no determin	ot be 200 Blood of Init	y Year) ury - At h	28b. Time of Injury	M 1	☐Yes 2☐No		ow injury occurred Street and Number or n, State)	Rural Route Number,		
	the Hospit thin 24 hour the Funera mpletely fills	Medical (29a. Certifier (Check only one) Certifying Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examina	owledge, death	vestigation, in m	time, date and place y opinion, death occ	urred at the time, o	cause(s) and manner date and place, and d	ue to the cause(s)		
	1 1)		30. Name and address of person w	3. Mo	eath (Item	n 23ar (Type.	T	>229	799	Sanvary	04,2007		
	Sta Regist		DR Countney 31. Date filed (Month, Day, Year).	MCC in 32 Registra	sky	1 900	0 Fran	Klin Sq	juare D	nue Ball	Move Md 2123		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per fb 863 1-5-07 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** BEN AMIN DAROTHY UNOUR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PTHUEST HOSP (TAZ RANDAUSTOWN BAUTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F Days Hours 24 Director 82 1924 MD 217-16-8156 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore MD NA X⊓Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3522 Milford Mill Road 21244 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ Specify: 3€ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade na Home Maker House 17. Father's Name (First, Middle, Last) Thomas Smith 18. Mother's Name (First, Middle, Maiden Surname) Be Eugenia M. Smith Hilda Hall မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Everall Ave Apt 212, Baltimore, Eugenia M. Smith 206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/6/07 Randallstown, Md tura of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disc ase or condition refulting in death) ADIOVASCULIR Physician THYLOSCIEROTIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a er death. Division or Vital Records, P.O. Box 68760 burial-tran and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent p/egnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2√ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours a er death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURT ROAD MARYLAND BOTHKIN 040 2ADAWSTOWN 5401 211 31. Date filed (Month, Day, Year) 32 degistrar's Signature State Registrar JAN 0 5

amend item 10e per ft 2863 1-5-07 yt state of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Louise Bonner 2007 Dnuary /Medical Town, or Location of Death Facility Name (If not institution, give street and ny 4c. County of Death Examiner If Under Social Security Number 8. Date of Birth (Month, Day, 03 21 Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🙀 F Months Hours 89 220-24-5396 VA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 TYYes 2 No Director Baltimore MD NA 10e. Street and Vimbelet 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. Ave Apt 406S Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 🔀 No Black Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Maryland 21215-0 any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 8th gradé nă 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Henry Taylor Mable Bonner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Weldon McLeod Sr.-Godson 3713 MacTavish Ave, Baltimore, Md 21229 Department of Health Important: If item 27 timore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages X□ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Memorial Park 1/5/07 Randallstown, King permit. 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee 21215 Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. has been signed by the a second be a should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tyes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed certificate 2 1 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ٥ 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ò To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License numbe 30. Name and address of person State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16a per fh e863 1-5-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician January 2, 2007 9:48 A M Basil Melville Burton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 216-14-4606 Yrs August 19,1919 87 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 X No iral", or Items 23a or 28a-f sh Examiner must be notified Director MD Baltimore Timonium 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 319 Quaker Ridge Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation Industrial work done during most of working Industrial Arts Teacher 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Rosella Lloyd Edmund Melville Burton Pages 1 and 2 should other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Monterey Olive Burton/Wife 319 Quaker Ridge Road Timonium, MD 21093 20b. Place of Disposition (Name of cemelery, crematory of other place)
Hereford Baptist
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 5, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Hereford, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Signature of Funeral Service Licensee Wanda L. Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 on CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 5 ☐ Pending investigation 1 Natural nours after death. Ineral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State DHMH 17 Rev 1/2001

To the I within 24

29b. Signature and title of certifier

mo ath (Item 23a) (Type, Print) 25205

Charles St. Bato. md 2120%

29d. Date signed (Month, Day, Year)

and manner stated.

Bernstain

Known as Charles

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral.

D42844 01-04-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in the BATHNOSE MD 21217 Kithleen Mother MD Mt. Ra 1501

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 0 4

29a. Certifier



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

	- FOI	epartment of Health and Mental Hygi Certificate of Death	ene, 007 00014
Division	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year
Physician /Medical	THERESA ROSE BROWN	Danyay	4 3 2007 1:25 P.M.
Examiner		4b. City, Town, or Location of Death	Anne Arundel
	Baltimore-Washington Medical Cent 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth	
Funeral Director		rs. Months Days Hours Min. (Month, Day, Aug. 31	,1925 Maryland
2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		10d. Inside City Limits
ehov			1 MYes 2 □ No
the N	Maryland N/A Bal	ltimore 10f. Zip Code 10	Og. Citizen of What Country?
MM	602 Arson Avenue	21225	U.S.A.
death death	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 Se	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married If Yes, Give	1 ☐ Yes 2 M No Specify:	Specify: White
21215-0036 dwithin 72 hours after giene. The "natural", or its the Medical Exercises.		Decedent's Usual Occupation	16b. Kind of Business/Industry
115-115-115-115-115-115-115-115-115-115	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	TOD. Rind of Edulites with dustry
121215-00 ed within 72 hou ygiene. The Medical Ent. It the Medical Ent.	Elementary/Secondary (0-12) College (1-4or 5+)	Housewife	Home
ind be file tal Hys d other event,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, N	
Viant Ment	George A. Ochs	Gertrude	(Unkown)
Maryland nd should be fitted and Mental Hy 27 is marked oth retraumatic even in To Box		Mailing Address (Street and Number or Rural Route Number, O2 Arson Avenue, Baltimore, M	
G. 1 end 1 end 2 mither in their in the interval in the i			20c. Location - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notitied at once.	resounal 2 Cremation 3 Premoval from State		len Burnie,Maryland
Baltir Permit Poparim Importar	21. Signature of Funda Service Licenses	22. Name and Address of Facility	21227
9 9 9 9 9	find & Tours	McCully-Polyniak Funeral Ho 237 East Patapsco Avenue, B	me P.A. 21225 altimore, Maryland
	23a. Perty Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		est, Approximate Interval Between
Physician	Imprediate Cause (Final disease or condition	heart tarline	Onset and Death
/Medical Examiner	resulting in death) Due to (or as a donsequence of	1):	
	Securitially list conditions b. Due to (or as a consequence or	it): \	
oxecuted and inal-frensit	Securitary is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	mon.	
8760,	resulting in death) Last Due to (or -s conservence or	#):	
S, P.O. Box 68760, < set that the death certificate be executed gned by the ettending physicien and be detached for use as the burial-trensit	d		
OX 61	IF FEMALE: 23c. If yes, outcome of pregnancy		20d Date of delivery
Box 6 eath certif ettending for use at	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Feld death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
P.O. that the ded by the detached	1 Yes 2 No 9 Unknown		
S, P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tot	pacco use contribute to the cause of death?
Cord		1 Ye	es 2 No 3 Probably 4 Unknown
law r		24a. Was a autops	y prior to completion of cause of
al Re in The licete here		perform 1 □ Yes 2	ned? death? 2X No 1 ☐ Yes 2X No
Vital		26. Place of Death (Check only of	
on of Vita Jing Physician: After this certific funeral director,		ime of 28c. Injury at 28d. Describe ho	ow injury occurred
rision Attending death. octor: Afte	1	njury Work? M 1 □ Yes 2 □ No	
Division of Vital Records, to attending Physician: The law requires to effer death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	27. Magner of Death 1 Delatural 5 Pending 2 Decident investigation 3 Duicide 6 Could not be determined starting building, etc. (Specify) 28a. Difte of Injury (Month, Day Year) 28b. T See. Place of Injury 28b. T In See. Place 28b.	rm, street, lactory, office 28I. Location (St City or Town	reet and Number or Rural Route Number, n, State)
Dissell o			
Division of Vital Records, P.O. Box 66 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funerel Director: Affer this certificate has been signed by the eltending p completely filled in by the funeral director, page 2 should be detached for use as it	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, and due to the ca d/or investigation, in my opinion, death occurred at the time, date in the time, date	ause(s) and manner as stated. ate and place, and due to the cause(s)
To ti with; To ti comp	29b. Signature and title of certifier	29c. License number 2	9d. Date signed (Month, Day, Year)
•	WO WO	D4397/	arron 3 2007.
6	30. Name legaddress of person who completed cause of death (Item 23a) (Type, Print) Rue, Clen Brome.	mo 21061.
State			
Registra	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Species .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2 Date of Death Month Day Year 2306 January BLUMENTHAL 01 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A Johns Hopkins Baltimore Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/27/1931 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🔽 F MD 75 Yrs. 217-26-1511 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 1 GRISTMILL COURT #408 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married

1 ☐ Yes 2 ☐ No

HOMEMAKER

PHILLIPS

20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ARLINGTON CHIZUK AMUNO 1/3/2007

Specify:

REBA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 E. HAMBURG STREET - BALTIMORE, MD 21230

Specify:

OWN HOME

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

20c. Location - City or Town, State

BALTIMORE, MD

WHITE

LAMPE

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any righty or other traumatic event, the Marklaal Examinational be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

ပ

ABBY

Inc

10a. State

MD

3 X Widowed 4 □ Divorced

Elementary/Secondary (0-12)

JOSEPH

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

STUART BLUMENTHAL / SON

1 🕅 Burial 2 □ Cremation 3 □ Removal from State

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit ate has been signed by the page 2 should be detached : After this certification of the funeral director, p within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Licen	ISOO TO THE PROPERTY OF THE PR	22. Name and	Address of Facility S	OL LEVINSO	N & BROS	., INC.				
	Rocot /	-h	8900 R	EISTERSTOWN	ROAD - PI	KESVILLE	, MD 21208				
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition	a MYOCARDIA	L INFAR	CTION			3 DAYS				
	resulting in death)	Due to (or as a consequence									
miner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bue to (or as a consequence	THERES								
al Exa	resulting in death) Last	Due to (or as a consequence of):									
/Medic	IF FEMALE:	23c. If yes, outcome of pregnancy				004 8-4-44	2377 - 10-10-				
ysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic preç 5 □ Other (spec			23d. Date of de Month	Day Year				
ed by Pr	Part II. Other significant conditions of DIABETES MELL	ontributing to death but not resulting - i ていら	in the underlying cau	use given in Part I.	23e. Did tobacc		the cause of death?				
Be Completed by Physician/Medical Examiner						autopsy prior to completion of cau					
3e (25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)						
2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O	utpatient 3 DOA	Other: 4 Nursing H	lome 5 Residence	nce 6 Other (Specify)					
ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe how in	ijury occurred					
ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory,	office	28f. Location (Street City or Town, St		ural Route Number,				
Medical Certification; To		ysician: To the best of my knowledg niner: On the basis of examination a and manner stated.									
Me	29b. Signature and title of certifier	0	29c.	License number	29d. I	Date signed (Mon	h, Day, Year)				
	Sy-ja	MEDICINE RE	SIDENT R	ES-000	JA	NUARY S	1,2007				
	30. Name and address of person who RYAN TEDFORD, MID			ET RAITIN	INDE MAR	LYLAND	01287				
te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Grade)		See I See Land Line Control of the C	- 1 - 1 1 - 0					
	JAN 0 4 200	1 State of the									
001		<i>y</i>									

DHMH 17 Rev 1/2

Registi

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Theresa Baker 5:00 PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Elkridge

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

Tully 5, 1931 Howard 6703 Hanley Drive 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Scot Land 1 □ M 2 💢 F 212-40-7419 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Elkridge Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 **USA** 6703 Handley Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 2 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EEG Technologist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owen Breslin Susan McLaughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2588 Thompson Drive Marriottsville, MD 21104 Kevin Baker / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 01/02/07 Metro Crematory Inc. 21. Signature Funeral Service License Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each linge. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cereborns lav /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ this I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospitai or Attending Physician: The law requires that the death certificate be executed within 24 hours a

> cause of death (Item 23a) (Type, Print) 405 atro 31. Date filed (Month, Day, Year, 32. Registrar's Signature IAN 0 2

and manner stated.

10

State Registrar 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of Maryland	•	tificate				Rag. No.	0 0 1		
	Physici	an	1. Decedent's Name (First, Middle, Last)	740					2. Date of De Month	Day	Year	3. Time of Death	
)	/Medic	al	JOSEPH C3 4a. Facility Name (If not institution, give si	'		4b. City. 1	Town, or Lo	ocation of Deat	24N	2 4c. C	ounty of Death	229011	
	Examin	er	COOD SAMARITAN			_		MORE		N/A			
ŝ	Funeral Director		5. Social Security Number 213-16-9816 6. Sex	7. Age (In yrs. la M 2 F 85	st birthday) Yrs.	If Under Months	1 Year If	Under 24 Hrs Hours Min.	8. Date of Bir	th y, Year) 192	9. Birthpi Coun Mar	ace (State or Foreign try) YLand	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation			-		11	0d. Inside City Limits	
	Maryl	ţō	Maryland Harford	d		White	Hall	·				1 □Yes 2 No	
	or 288	Oirec	10e. Street and Number			10f. Zip					on of What Coun	try?	
	s 23a	rai	5321 Broadway Ro		140	W D		1161	S		U.S.A. 14. Race - American Indian,		
5-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show te Madical Exert int nius! te notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decement Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II	1 XYes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☒ No Specify: 11. Race - American Black, White, etc. Specify: Wh					
<u>ဂ</u>	72 hours 'natural', dical Exa	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usua kind of won	l Occupation	on ing most of wo	rking	16b. Kind	d of Business/Inc	dustry	
7	within ane. than '	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. i	DO NOT US CLER				R	Railroad		
מ	Hygid other	Be Co	17. Father's Name (First, Middle, Last)	I		ccei		B. Mother's Na	me (First, Middle				
/iand	Menta Menta mrked artic ev	To B	Alphonsus Citr	0				Loret	ta St	ocker			
Mary	and I		19a. Informant's Name/Relationship (Typ			-			ural Route Numb			_	
	ges 1 and it of Healti if Item 27 or other 1		Margaret Citro	(wife)	3321 ace of Dispo metery, crer			Road,	White Ha		1D 2116 ation - City or To		
Baitimore,	permit. Pages Department of I Important: If It Important: Journ Injury or o		1 □XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Mosa Mosa	t Holy	Rede	emer.		/2007				
g	perm Depe Impo any i		21. Signature of Furieral Service License	2					chimunek Baitimor			es	
-			23a P. nt. Enter the disease, or compli- shock, or heart failure. List only	alimns that caused the death.								Approximate Interval Between	
	Physician	Immediate Cause (Final disease or condition											
	/Medical Examiner		resulting in death)	Due to (or as a consequent									
	1.0	ē	Sequentially list conditions, b.	Due to (or as a consecu	CYS7	1117							
4	outed id ansit	Examiner	Sequentially list conditions, 1 any, leading through the cause. Enter Underlying Cause (Disease or injury that initiated events	URINARY	TRA	CT	IN	FECTI	J.N				
Ď,	e exectan ar		resulting in death) Last	Due to (or as a consequ	ence of):	,	Λ		59.11				
68/60,	icate be executed physiclan and s the burial-transit	edical	d	ALEN STE	LLS	-	PNEL	MONI	A.				
Box	certif nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Continue C								23d. Date of delivery Month Day Ye		
o.		hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	u 3C	2 0 1101 (3)00	JUNY		444				
S,	s thi	by P	Part II. Other significant conditions con		-		1		23e. Did	tobacco us	e contribute to th	ne cause of death?	
ord	w require been sig should b	ted	HYPERTENSION.	CORONARY	ART	ERT	التر4	EASE	10	Yes 2	No 3 ☐ Prob	ably 4 Onknown	
Š	has b	Completed							24a. Was		prior to coi	psy findings available inpletion of cause of	
Vital Records,		e Co	OF Ween and and to see that						1 ☐ Yes	2 N O	death? 1 ☐ Yes	2 No	
	Physician: this certific ral director,	0 8	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1.XInpatient 2	ER/Outpatier	nt 3 DO	Othor		ath <i>Check</i> only Home 5 Res		□Other (Snecif	vI	
ion of	ing After une	ation: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		28b. Time o Injury		8c. Injury at Work?		28d. Describe			,,	
Division	i Si th o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	reet, factory	, office			Street and wn, State)	Number or Rura	l Route Number,	
	5 4 1 9	edical	(Check only one)	ing Physician: To the best of my knowledge, death occurred at the time, date and place and due to the coll Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, diand manner stated.							und marmer as so place, and due to	tated. o the cause(s)	
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	, , ,	_		License n				signed (Month,		
•			1. 4. 6	- M	0		RÈS-				in 2, 7		
	2541		30. Name and address of person who co	mpleted cause of death (Item 5601 Lock)	23a) (Type,	Print)	RIV	D F	SA, TTO	10 E	MX	21239	
0	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	12/2 2	000	- 1	01/1/1/10/1	I I	/ 10,	-1201	
40	Regist	rar	JAN 0 5 200	Section States Sel	A STATE OF THE PARTY OF THE PAR	Continue of the last							

JOSEPH

/-0001/	- 11	Please Type or Print in Black Indelible Ink. Ensur	
ernard Campbe		State of Maryland / Department of Health an 1-For State Certificate of Death	7011/111111
Physicia		Registrar	Reg No. 2. Date of Death 3. Time of Death
/ledical Exami	ner	BERNARD CAMPBELL	January 1, Day Year 1304 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or University Hospital Baltimore	Location of Death 4c. County of Death N A
Funeral	٩	5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Yea	
Director		218.88.3649 1@M 2 F 46 Yrs Months Day	ys Hours Min. 02 · 18 · 1960 Foreign Country) SC
8		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits
d now any e.		mo RATIMORE	1 K Yes 2 No
Maryland 28a-f show datonce	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
15-0036 filed within 72 hours after death with the Maryland Hygiene of other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be norfited at once		1-10: 10:10:10	29 USA
th with terms 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi 1 Never Married 2 Married Armed Forces? If Yes, specify Cuba	ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
ter dea			o specify Specify BLACK
ours af atural xamin	d by	or Dates:	ation (Give kind of work done 16b. Kind of Business/Industry
)036 within 72 h iene er than "n Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-003 ied withi tygiene other th		12 TH GRADE N/A CARPENTER 17. Father's Name (First, Middle, Last)	MARBLE DESIGN 18 Mother's Name (First, Middle, Maiden Surname)
21215-0036 suld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be (JOE CAMPBELL	DAISY BOWMAN
Sho Sho	ř	DAISY CAMPBELL (MOTHER) 3931 ROKEBY	ret and Number or Rural Route Number, City or Town, State, Zip Code) RD., BAITIMORE, MD 21229
ore, M ss I and 2 of Health If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of ce crematory or other place)	emetery, Date 20c. Location - City or Town, State
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other Specify: MT - XION	01.06.01 BALTIMORE, MD
Bal permi Depar Impo		21 Signature of Funeral Service Licenses VAUGHN C 5151 BAUD.	GRÉENE FUNERAL SERVICE NATU PIKE, BALTO, MD 21229
Physician		23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying failure. In only one cause on each line.	g, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
		Sequentially list conditions, b	
	Examiner	if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated c	
ecuted and transit			
al al	sician/Medical	X UNPENDED #23a,27,28a-f, perME, C863	1/22/07 TT
Box 68760, a death certificate be the attending physici af for use as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d Date of delivery Ectopic pregnancy Month Day Year
x 68 th certi	iciai	past 12 months? 1 Live birth 2 Fetal death 3	Locopic pregnancy World Day Teal
. Bo he dear y the ar	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I 23e Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. E rat or Attending Physician: The law requires that the c rs after death. at Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	ð		1 Yes 2 No 3 Probably 4 Unknown
ords, w requir s been s should!	Completed		24a Was an 24b. Were autopsy findings available prior to completion of cause of
eco The Taw ate has	dwo		performed? death? 1 Ves 2 No 1 Ves 2 No
tal Recition: The certificate ector, page	Be	25. Was case referred to medical 26.Plac	ce of Death (Check only one)
f Vit	ToE	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	Other ₄ Nursing Home 5 Residence 6 Other:
on of anding Ph. th. : After t	ion:	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Inj 1	Yes 2 X No Subject fell down stairs
VISIOF or Attend frer death Director: in by the	ficat	2 X Accident Investigation Find 12/30/2006 Find 9:30 pm 28e. Place of Injury - At home, farm, street, factory, office	building, etc. 28f. Location (Street and Number or Rural Route Number, City
Div Hospital o 24 hours aff Funeral D	Certification:	3 Suicide 6 Could not be determined (Specify) House	or Town, State) 1406 Ward Street Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical		
F 3 F 8	Me	29b. Signature and title of certifier 29c. Licen	nse number 29d. Date signed (Month, Day. Year)
		fantite money, my	C.M.E. January 2, 2007
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 21201
	tate		
Regis	-		
OCME 2006	061	ORIGINAL	

0/-0001/

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28s-f ahow any injury or other traumatic event, Tra Marical Examinar must be rectified at once.

Physician

To Be Completed by Funeral Director

	Please	Type or Prin	it in Blacl	k Inde	lible lr	nk. Ensi	ure All	Copies A	re Legit	ole.	
For		State of Ma	-					ental Hygi	ene		
State Registrar				Certif	icate d	of Death	7	Re	g. No? () [17	00020
Decedent's Name	e (First, Middle, La	st)						Date of Death Month		Year	3. Time of Death
			anapp					January	1, 200		6:00 A
		e street and number)	- 10	46	4b. City, Town, or Location of Death Parkville					of Death	imore
5. Social Security N		Care Cent	e (In yrs. last birt	thday) If	Under 1 Y		7 24 Hrs.	8. Date of Birth	1		place (State or Foreig
214-20-67 Usual Residence of	77	□M 2 X □F				ays Hours	Min.	Apr. IZ,	Y°¶'926	Cou	yland
10a. State	10b. County		10c. City, Town	n or Location	on						10d. Inside City Limit
Md.	Balt	timore			Park	ville					1 ☐ Yes 2 X O(N
10e. Street and Nur	mber			1	Of. Zip Co	de		10	g. Citizen of W	/hat Cou	intry?
8832 W	alther Bo	oulevard				2123	4			USA	
11. Marital Status		12. Was Decedent ! Armed Forces?	Ever in U.S.	13. Was	Decedent	of Hispanic O	rigin? (Spe	cify Yes or No- Rican, etc.)		e - Amer k, White	ican Indian,
1 Never Marri 3 XWidowed	ied 2 Married 4 Divorced	lo .		Yes 2.0X			Tilodin, Oto.,	Specify		White	
(Soec	15. Decedent's Ed	ducation	16a.	Decedent	of work di	one durina mo	st of worki	na 1	6b. Kind of Bu	siness/li	ndustry
Elementary/Seco		College (1-4or 5	+)	life. DO I	<i>NOT use re</i> e Mak	etired)	o. o. Horan		Own H	Omo	
17. Father's Name	(First Middle 1 ast	,		HUIII	e riak		ner's Name	(First, Middle, M			
						TO. WIOLI		helma l	. Mil		
	ieorge I ame/Relationship (10h	Mailing A	ddraes /St	reet and Numb		I Route Number,			in Code)
Mr. Earl			4			rse Dr		Phoenix,			
20a. Method of Dis		1/ 3011	20b. Place of	Dispositio	n (Name o	of !			Oc. Location -		
4 Donation	5 ☐ Other (Specif	1	Gardens		Faith	Cem.	1/5/	07 Ov	erlea,	Mar	yland
21. Signature	ineral S rvice L	Que/M				k Road		k Towsor son, Mar			lome, Inc. 14
23a. Part1. Enter to shock, or hea	he disease, or com	plications that caused one cause on each lin	the death. Do r	not enter th	ne mode of	dying, such a	s cardiac o	or respiratory arre	st,		Approximate Interval Between
Immediate Cause disease or condition	(Final		a.a. A.	اء ا		Disea	-61			ļ	Onset and Death
resulting in death)	•	a. Due to (or as	a consequence		tery Disease						10 years
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying injury	bDue to (or as	a consequence	of):							
that initiated events resulting in death) i	5	Due to (or as	Due to (or as a consequence of):								
	•	d									
IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	menths?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		topic pregn her (s <i>pecif</i>				23d. Dat Mor		very Day Year
Part II. Other signif	ficant conditions	contributing to death b	ut not resulting in	n the under	rlying caus	e given in Part	ı.	23e. Did tob	acco use contr	ibute to	the cause of death?
Periph	read liv	tery 1)15	ease					1 □ Ye	s 201No	3 🗆 Pro	bably 4 Unknow
Atlance	denti	Dozane	سان					24a. Was an	24b. V	Vere au	topsy findings availab
1111200		Dewe						autopsy	ed?	prior to cleath?	ompletion of cause of
25. Was case refer examiner?	red to medical	Heaviel					ce of Death	(Check only one)		
1 □ Yes 2		Hospital: 1 Inpatie			3□ DOA			me 5 Reside			erfy)
27. Manner of Deat 1 SNatural 2 Accident	th 5 Pending investigatio	28a. Date of Inju (Month, Da		Time of injury	28c.	Injury at Work?		28d. Describe ho	w injury occurr	ed	
3 Suicide 4 Homicide	6 Could not be determined		ury - At home, fa	ırm, street,	factory, of	fice		281. Location (Str City or Town		er or Ru	ral Route Number,
29a. Certifier (Check only one)	1 Certifying Pl	nysician: To the best miner: On the basis of and manner st	examination an	e, death oc ad/or invest	curred at th	he time, date a my opinion, de	and place, a	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as and due	stated. to the cause(s)

29c. License number

BILL

D30182

Baltimore.

29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bross after death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the tunneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) with Am m. M. 58ell 8200 Wolldon

32. Registrar's Signature

State **Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Marviand 8863 atment of Mealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02, 2007 **Physician** WILLIAM R. CLEMM рм January 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 3514 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 206-52-3574 65 Director March 09,1941 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Dauphin Harrisburg Pennsylvania 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17103 U.S.A. 3324 Green Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mentally Challenged 0 Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Kathleen Lowe Burd Clemm Sr. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Sycamore Street, Baltimore, Maryland 21226 Anna K. Stinefelt (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Pleasant Cem. 01/06/07 Dauphin, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VIVOSEPES days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month 5 Other (specify) been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dehydration 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Steed Beck, MO D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, anhapths HD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 0 4 2007

32. Registrar's Signature

			For State Registrar	State of Ma	ryland		artment rtificate				giene? (07	00022
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last Georgianna Louise 4a. Facility Name (If not institution, give	Boyd			4b. City,	Fown, or	Location of Death	2. Date of Dea Month	Day	Year 2007 ty of Death	3. Time of Death 22: 47 PM
	Funeral Director	lel	Franklin Squar 5. Social Security Number 6. Se	re Hosp	ita (In yrs. las	st birthday) Yrs.	R	SEC	If Under 24 Hrs. Hours Min.		P	9. Birthp	olace (State or Foreign olary) cylvania
_ i	_	ctor	Usuat Residence of Decedent 10a. State 10b. County Maryland Balt	cimore		Town or Lo		ville		101 20 130			0d. Inside City Limits 1 ☐ Yes 2 🔀 No
una 1	rs etter death with the Maryland i, or Items 23a or 28a-f ehow xaminer must be motified at	by Funeral Director	10e. Street and Number 8204 Woodside Court 11. Maritat Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 X N If Yes, Give Year or Dates:		1	10f. Zip Was Deced If Yes, spec	2123 ent of His rty Cubar		pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White		
ď, Éjebrgi Unna Marvland 21215-0036	filed within 72 hours Hygiene. tther then "neturel", ent, the Medical Ex-	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ıcation		(Give	dent's Usua kind of wor DO NOT us 1001 Te	acher	uring most of wor	rking ne (First, Middle,		cation	dustry
1, Gl	d 2 should be filed within and Mentel Hygiene. 7 is marked other then traumatic event, the Mentel Hygiene.	To Be	William Nolan 19a. Informant's Name/Relationship (7)				-	(Street a	Bessie	BOCK	er, City or Tow	n, State, Zip) Code)
Boyd,			Kimberley D. Nonato - 20a. Method of Disposition 1 \(\Sigma \) Burial 2 \(\Cremation \) 3 \(\Sigma \) 4 \(\Donation \) 5 \(\Other \) (Specify	Removal from State	cen	ce of Dispo	Pikes psition (Name and or	ne of ther place	9)	mantown, I	20c. Location	n - City or To	own, State
Balti	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Lines. 21. Signature of Funeral Service Lines. 22. Signature of Funeral Service Lines. 23. Part 1. Enter the disease, or comp	ines A		1	eonard	J. R	s of Facility UCK, Inc.	Baltimo	rford Ro re, Mary	ad	
68760.		dicai Examiner	shock, or heart failute. List only of timediate Cause (Final disease or condition resulting in death)	ne cause on each lin	scleva conseque	once of):				Hicut]			Initerval Between Onset and Death
P.O. Box 6	ettendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetat d	leath 3[∃Ectopic pro ∃ Other (sp					Date of delive Month	ery Day Year
cords, P	w requires that been signed t should be det	۵	Part II. Other significant conditions co	ntributing to death bu	it not result	ting in the u	inderlying ca	ause give	n in Part I.	101	∕es 2□No	3 ☐ Prob	
Division of Vital Records,	ding Physician: h. Atter this certific funeral director,	ation; To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Leath 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 2	R/Outpatier 28b. Time o In i ury		8c. tnjury Work	4 🗆 Nursing H	24a. Was autor perio 1 Tyes ath Check only o dome 5 Resident 28d. Describe h	osy rmed? 2 No one dence 6 C	death? 1 ☐ Yes	ppsy findings available impletion of cause of 2 No
Divis	₹ 5 <u>9</u> 9	ical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc building, etc iner: On the basis of	t my know	Nediga, derat	h Socumed	at the time	e date and place	City or Tov	vn, State)	Tanner as t	al Route Number,
•	To the Hospi within 24 hour To the Fune completely fil	Medical	29b. Signature and title of certifier Clana Wa 30. Name and address of person who of	and manner sta	'.D.		290	. License	number		29d. Date sig	ned (Month,	
	Sta Regist		Dr. Ed and Ma 31. Date filed (Month, Day, Year) JAN 0 3 20	32 Registra	Fro	ankli	n Sq	lar	e Dri	ve B	altim	ore, h	VID. 2123

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January Lillian Frances Dorries /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 8,1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🔀 F 216-03-9061 88 May Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Md. n/a Baltimore Director 10e. Street and Number 10f. Zip Code 434 Elrino Street 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Na Be William J. Borkowski Lena ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fi Gregory Dorries (son) 65 Cherrywood Cour 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility K a 1201 Dundalk Av tubot 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Box 68760, 🗻 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE:

23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Hospital: 1 ☐ Inpatient

address of person who completed cause death (Item 23a) (Type, Print)

6701

Registrar's Signature

28a. Date of Injury (Month, Day Year)

4☐Pregnant at time of death

8. Date of Birth (Month, Day, Ye May 8, 19	37)	Birthplace (State or Foreign Country)
мау 8,19	118	Maryland
		10d. Inside City Limits
		1X Yes 2 □ No
10g.		What Country?
nasifu Van - N-		S.A.
pecify Yes or No- o Rican, etc.)		ack, White, etc.
	Speci	White
rking 16b	. Kind of E	Business/Industry
	0	n Homo
ne (First, Middle, Maid		n Home
Zezulinsl		
ural Route Number, Cit	y or Town	n, State, Zip Code)
t Cockeys	svil	le, Md.21030
		- City or Town, State
		more,Maryland
		neral Home,PA , Md. 21222
c or respiratory arrest,		Approximate
		Interval Between Onset and Death
ncer		moth
	224 0	ate of delivery
		ate of delivery fonth Day Year
	<u> </u>	
	_	ntribute to the cause of death?
1 Tes	2 No	3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy		. Were autopsy findings available prior to completion of cause of
performed 1 Yes 2 ☐	No No	death? 1 □ Yes 2 □ No
ath (Check only one)		
forme 5 Residence		ther (Specify) Hopice
	., ,	•
28f. Location (Street	and Num	nber or Rural Route Number,
City or Town, S	ale)	
e, and due to the caus urred at the time, date		nanner as stated. e, and due to the cause(s)
		ed (Month, Day Year)
	7100	y 4, 2006
elto. nd	-	2
ano, pred	21	204

,200⁷

4c. County of Death

Baltimore

8:30 P.™

Division or Vital Records, P.O. Be Completed

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

(Check only

31. Date filed (Month

29a. Certifier

1 - For State Registrar

I or Attending Physician: The law requires that the death certificate be executed after closed.

Intercor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit filled in by within 24 hours a

To the Funeral I

þ

Medical Certification: To

State Registrar

completely

3 Ectopic pregnancy

26. Place of De Other: 4 Nursing

1 ∏Yes 2 ∏No

28c. Injury at Work?

29c. License number

5 ☐ Other (specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29d per dvr g863 1-5-07 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1 - For State Registrar	State of Mai		Departme <i>Certifica</i>			Mental Hy	giene Reg. No		00021	
Dhusisis		1. Decedent's Name (First, Middle, La						2. Date of De			3. Time of Death	
Physicia /Medic			lgadillo		1			Janu		3 2007		
Examine	er	4a. Fecility Name (If not institution, given 1005 Foxwood I				, Town, or SSEX	Location of Death		1	4c. County of Death Baltimore		
Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last bir	thday) If Und	er 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9 Birt		
Director		003-40-0730	□ M 2(3)F	99	Yrs. Months	Days	Hours Min.	Jan 1	,190	08 Don	thplace (State or Foreign puntry) NINICAN Oublic	
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					105	10d. Inside City Limits	
with the Maryland a or 28a-f show be notified at	ţŏ	MD Baltin	nore	Esse	x						1 ∐Yes 2x∑No	
or 28	Olrec	10e. Street and Number				ip Code			10g. Cit	izen of What Co	ountry?	
s 23e	ral	1005 Foxwood				1221			USA			
S 0 9	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		13. Was Dec If Yes, sp 1 X Yes		spanic Origin? (Sp n, Mexican, Puerto Specify: Don			14. Race - Ame Black, White Specify His	e, etc. spanic	
"natural	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's Us	ual Occupa	ition			DOM 1 N 1 ind of Business/	canRepuli Industry	
han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	eamstr		furing most of work)	ung		lothin	. ~	
filed within Hygiene. other than "	S	8th 17. Father's Name (First, Middle, Last))		Camsti	CSS	18. Mother's Nam	e /First Middle			19	
id be ental kad o ic ava	To Be	Basileo Delga					Barbir			osinao,		
2 should and Mer is marks aumatic		19a. Informant's Name/Relationship (. Mailing Addre	ss (Street a	and Number or Ru	al Route Numb	er, City o	or Town, State, 2	Zip Code)	
l and leatth m 27 her tr		Anna D. Aceve	do/daught				d Lane					
permit. Pages 1 and 2 should be filed within 72 ho Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic avant, Illia Madical once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specif		cemeter	Disposition (Ny. crematory or a Ther	other place	1/10	Date / 07	San	ocation - City or tiago Linican	Repulic	
Depart Import any in		21. Signatura of Fundal Service Licer	mul	25 h			s of Facility 30 Funera		e Av	enue B	Balto. MD	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	lications that caused the one cause on each line	he death. Do	not enter the mo	ode of dying	g, such as cardiac	or respiratory a	irrest.		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a COL	unai	y we	alt					Chisti and Death	
Examiner			Due to (oct 5	WW/	PAIN	w	untai	ct a				
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	carsequence	of): /	PA	2011	111	_			
ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	Much	las	lac	azra	aca				
licate be executed physician and s the burial-transit	S E		d d	consequence	or).		,					
	ledical	3	_ d									
The law requires that the death certifule is the stending to he stending to be a should be datached for use as a same to the set as a same to the same to th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic 5 □ Other (23d. Date of del Month	livery Day Year	
res that th igned by be datacl	by Ph	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying	cause give	en in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?	
w requires been sign should be				·				10	Yes 2	⊡ No 3□Pr	robably 4 Unknown	
e law re hes be	Completed							24a. Was		24b. Were au	utopsy findings available completion of cause of	
	Sol							perf	ormed? 2 ☑ No	death?		
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	26. Place of Dea					
ith. After this certifical funeral director, p	n: To	27. Manner of Death	28a. Date of Injury	28b.	Time of	28c. Injury Work	4 🗆 Nursing m	28d. Describe		6 ☐Other (Spe ry occurred	cify)	
endin sath. or: Aft he fun	atlo	1 Natural 5 Pending 2 Accident investigation		rear) I	njury M		res 2 □ No					
s efter dan Diract	Certification:	3 Suicide 6 Could not b 4 Homicide determined		y - At home, fa (Specify)	rm, street, facto	ory, office		28f. Location City or To	Street ar wn, State	nd Number or Ru e)	ural Route Number,	
To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certification of the funeral director, completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	nysician: To the best of miner: On the basis of e and manner state	examination an	dor investigation	d at the tim	e, date and place, pinion, death occur	and due to the red at the time,	cause(s)) and manner as d place, and due	stated. to the cause(s)	
To the To the comp	ž	29b. Signature induttle of certifier	0. 1		1	9c. License	number		29d. Da	te signed (Mont	h, Day, Year)	
		Null	uu_		1	710	613		1-4	+-20	υ/	
2		30 Name (Ind address of person Mino	REFINE	ath (Item 23a)	(Type, Print) 404	EF	HIPTERN	BW	0_	212	71	
Stat Registra		31. Date filed (Month, Day, Year) JAN 0 4	32. Registrar	s Signature	Coast	5						

		•	For State Registrar		State of	Marylan		artment of Hertificate of L		nd Me		giene Rag. No.		7	00	025			
	Physicia /Medic	an 📗	1. Decedent's Name (First, Midd	-	1)	10100	o				2. Date of Dea Month	ath Day	, Y	ear	3. Time				
}	Examin	er	4a. Facility Name (If not institution Oak Crest Care Ce	nter				Par	4b. City, Town, or Location of Death Parkville				c. County of Déath Baltimore						
	Funeral Director		5. Social Security Number 213-10-4873 Usual Residence of Decedent	6. Sex	M 2□F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da) 2-09-191	y, Year)		Cour	try)	or Foreign Marylan			
	ith the Maryland or 28a-1 show		10a. State 10b. County	altim	ore	10c. City	, Town or Lo	cation DWSON						1	0d. Inside 1 ☐ Ye	City Limits			
	h with the 33 or 28a st be noti	Funeral Director	10e. Street and Number 826 Scarlett Dri	ve				10f. Zip Code 2128	36			10g. Cit	izen of Wh		itry?				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exar', in arr and be multipled at Ance.	þ	11. Marital Status 1 Never Married 2 X Mai 3 Widowed 4 Divorce	ried	2. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? [X]No		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Orig n, Mexican, Specify:	jin? (Spec Puerto P	cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White,	etc.				
21215-0036	d within 72 h giene. er than "natu r ne Mudical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12			lor 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, CE Captain	uring most	of workin			ind of Busi		ty Police Dept.				
Maryland	ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle Paulino DiPino						Jer	nnie M	Mandello		Maiden Sumame)						
	nd 2 sho aith and 27 is m ir traum			Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 esina E. DiPino – Wife 826 Scarlett Drive Towson, Maryland 21286										ate, Zip	Code)				
Baltimore,	ages 1 a ant of Hea nt: If item y or othe		20a. Method of Disposition 1 1		moval from St	ate C	emetery, crer	sition (Name of natory or other place ley Mem. Gai					Location - City or Town, State Onium, Maryland						
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service		mes.	6	22	2. Name and Address Conard J. Ri	s of Facility	/ 5	305 Hart Baltimore	ford	Road		14				
	Physician /Medical Examiner		23a. Part 1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complic t only one		31.0.	WW		g, such as c	cardiac or	r respiratory ar	rrest,			Approxim Interval B Onset and	etween			
8760,	rate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d.		r as a consequence of as a consequence of the conse													
P.O. Box 68	n requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unknown 2								23d. Date Monti		ary Day	Year						
	quires that in signed b uld be deta	ed by Pt	Part II. Other significant condit	ions conf	ributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.				use contrib	ute to ti		f death?			
Division of Vital Records,	> -0 75	Completed by			•								pri de	or to co ath?	psy finding mpletion of 2 \(\text{No} \)	s available cause of			
fVita	ysician is certif director	To Be	25. Was case referred to medic examiner? 1 Yes 2 No		spital:	patient 2	ER/Outpatier	nt 3 DOA Othe			(Check only one 5 ☐ Resid		6 □Other	(Specif	y)				
ion o	nding Pt ath. r: After the e funeral	ation:	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	ng igation	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	Work	rat ⟨? Yes 2 □ N		8d. Describe	how inju	ry occurred	1					
Divis	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could deter	not be mined	28e. Place o building	f Injury - At ho g, etc. (Specif	ome, farm, sti	reet, factory, office		2	8f. Location (S City or Tox			or Rura	al Route No	ımber,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Cartify (Check only one)	ng Phys I Examin	er: On the bas and manne	sis of examina	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	oinion, deat	d place, a th occurre	ed at the time,	date an	d place, an	d due t	the cause				
	To the within To the comp	W	29b. Signature and title of sectif		Oh	e i	u)	29c. License	number	12		29d. Da	te signed (Month,	Day, Year,)			
	12 1		30. Name and address of payson	who cor	npleted cause	of death (Item	23a) (Type,	Print)	276	u A	Noi	Pa	rkul	lc	My.	4134			
	Sta Regist		31. Date filed (Month, Day, Yea	3 201	32 Re	gistrar's Signa	tuce	made)											

Dipino, James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:08 PM EDWARDS EUGENE 2007 IAN' 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE OHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 213-54-3043 56 keg wist 20, 1950 Director Mn Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Examiner must be notified Homone Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21.202 USH or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced 'natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Baker permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Item 27 is marked any Injury or come. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Cli Fton Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patsy Edwards, 929 Web6 Court Baltimone MD Sister-IN-Lan 21202 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 105 40 21206 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STEVENS JOHNSON Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HIV/AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for on a novelessment of Examiner NEUMONIA for use as the burial-tran Due to (or as a consequence of) attending physician pe SEPSIS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page 2 has death? 1 ☐ Yes certificate 2 No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō

State Registrar DHMH 17 Rev 1/2001 (Check only

EVON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MIFADDEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

Saltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

4940 EASTERN AVENUE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

02

JANUARY

MD

BALTIMORE

2007

			For State Registrar	State of Maryl		partment o ertificate d		7		Reg. No.	7 00027
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Pet Aa. Facility Name (If not institution, give s		on	4b. City, Tow	n, or Location		Date of Dea Month	Day, Y	Gear Grant G
	Funeral Director		5. Social Security Number 6. Sex 246-09-3589		yrs. last birthda 86 Yrs.	y) If Under 1 Your Months Da	edale ear If Under ays Hours	Min. 8	. Date of Birt (Month, Da 9-4-19	y Year) No	Birthplace (State or Foreign Country)
	death with the Maryland me 23s or 28s-f show rmatte notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balt:	imore 10c	. City, Town or		e Rive	er			10d. Inside City Limits 1 ☐ Yes 2Ã☐Ño
	sth with the Marylar 23a or 28a-f show	Funeral Director	10e. Street and Number 603 Sopwith Drive			10f. Zip Coo	_{de} 212	20		10g. Citizen of Wh	uat Country? USA
036	b # #	<u>호</u>		12. Was Decedent Ever in Armed Forces? 2□XYes 2□No If Yes, Give Year or Dates: W	in U.S. 13	3. Was Decedent If Yes, specify (fy Yes or No can, etc.)	14. Race - Black, Specify:	- American Indian, White, etc. Black
Elbrow, Peter Baltimore, Maryland 21215-0036	"natur	Completed		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Linesman							
Pete yland 2	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic avant, it a Magnee.	To Be C	17. Father's Name (First, Middle, Last) Elijah Ebron					her's Name (a ry Whi		Maiden Sumame,)
Man	end 2 sho salth and P n 27 is ma ier trauma		19a. Informant's Name/Relationship (Ty) Diane Coley Dat	pe, Print) ughter						er, City or Town, Si C, Maryla	
Ebron,	Pages 1 of He not: If Item		20a. Method of Disposition ★☆Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		position (Name of rematory or other	1	1/6/20			ity or Town, State Virginia
回 Balti	permit. Departminporta		21. Signal up uneral Sew Livense					iss-Sei Road E	tz Fur Baltimo	neral Hom ore, MD 2	ne. Inc.
•	Physician /Medical Examiner	Examiner	23a Rart1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cations that caused the cause on each line. Cardia Due to (or as a cor	death. Do not e						Approximate Interval Between Onset and Death Own UTES
.68760	i i i i i i i i i i i i i i i i i i i	edical	resulting in death) Last		G (FIME)						
P.O. Box 6	nt the death certific by the ettending pl tached for use as t	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregn 5 □ Other (specif				23d. Date Mont	
	w requires that been signed t should be det		Part II. Other significant conditions cor	ntributing to death but not	t resulting in the	underlying caus	e given in Par	t I.	23e. Did t	L	oute to the cause of death? B Probably 4 Unknown
al Reco	icien: The law recentificate has be	Completed							24a. Was auto perfo 1 Yes	psy pri prmed? de	ere autopsy findings available for to completion of cause of sath?
<u> </u>	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Othor	ce of Death (
Division of Vital Records.	ttanding Phys death. tor: After this	ation: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpat 28b. Time Injur		Injury at Work?	28		dence 6 Other	
S Divis	: 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S)	At home, farm, pecify)	street, factory, of	fice	28	f. Location (City or To		r or Aural Route Number,
•	To the Hospitel within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, de mination and/or	eath occurred at the investigation, in	he time, date my opinion, d	and place, an eath occurred	d due to the d at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Janus L	1D	0	ES (0000	0	29d. Date signed	(Month, Day, Year)
	Sta Regist	ate	30. Name and address of person who co	ompleted cause of death	14. 9a	De, Print) O Frau V	lin Sq	uare	Drive	Baltin	ore, MD. 21237

07-00009 William Joseph	Elro		pe or Print intage						.egible			
		1- For State	tate of Maryle		rtificate of		na wienie	ar i iygicile	Reg. No	20	0.7	0002
Physicia	an/	Registrar 1 Decedent's Name (First, Midd	lle,Last)					2. Date of D	eath	Year		3 Time of Death
Medical Exami	ner	William Jos	seph Elro	od, Jr.				January	1, 2007			1031 hrs
		4a. Facility Name (if not instituted 12021 Three Bridge I		mber)		4b. City, Town. Cordova	or Location of	Death		County of albot	Death	
Funeral		5. Social Security Number	6 Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye Months Da	ear If Under	Min	Birth (MM/E	- 1	Foreign	
Director		217.74.9294 1 M 2 F 47 Yrs 01.18.1959 CC										ntry) MD
any		Usual Residence of Decedent 10a State 10b. County	·	10c. City,	Town or Locati	ion					1	10d Inside City Limits
*	-	MD Tall	oot	C	ordova							1 Yes 2 No
daryla 28a-f	Director	10e Street and Number				10f. Zip Code			10g Citiz	en of Wha	t Count	гу?
ith the Maryland 23a or 28a-f show notified at once.	وَ	12021 Three	e Bridge	Brach	Road	21625	<u>. </u>		U.	S.A.		
r death witi or items 2 must be n	neral	11 Marital Status 1 Never Married 2						n? (Specify Yes or Puerto Rican, etc.)	No-	 Race - White, 		an Indian, Black,
ter dea	Fun		1 Yes	2 No	1	Yes 2 X	lo specify:		1	Specify:	Whi	to
urs afi toral	d by	15. Decedent's Education (Spe	or Dates:		16a. Deceden	t's Usual Occup	oation (Give ki	nd of work done		ind of Busi		
6 172 ho	leted	Elementary/Secondary (0-12)	College (1	-4 or 5+)		ost of working li	fe. DO NOT u	se retired)				
5-0036 led within 7 thygiene other than	Comple	10	1		Carp	enter	Lantan	N (5) 1 16			tru	ction
11215-0036 Id be filed within 72 hours after dental Hygiene marked other than "natural", event, the Medical Examiner	Be C	17. Father's Name (First, Middle		. 1				Name (First, Middl				
2121 2121 July be fill Mental Fill marked	To E	Billie Jos	SEDN LIF ship (Type, Print)	ра	19b. Mailing	Address (Str	eet and Numb	rie Avo er or Rural Route	11a Number, Cit	HOIN by or Town,	eln State	L Z Zip Code)
nore, MD 2 ages I and 2 should in of Health and M it: If item 27 is not other traumatic		Sharon Ann	Elrod/wi		1202	1 Thre	e Bri	dge Bra	nch	Rd.	Cor	625 dova,MD
ore, se l'an of Hea If iten		20a Method of Disposition 1 Burial 2 remation	n 3 Removal fr		Place of Dispos crematory or oth	ition (Name of	cemetery,	Date	20c. L	ocation - (City or T	own, State
Baltimore, permit. Pages an Department of Hea Important: If ite		4 Donation 5 Other S	pecify:		esapea		em.	01.04.0	7 Be	ltsv	ill	e. MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental flygiene Important of Health and Mental flygiene Important: If tiem 27 is nanked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		2) Signature of Funeral Service	Licensee	MAIIII	2	lame and Addre		Cremati	on A	nd F	une	ralBalto
Physician		23a Part I. Enter the disease, o	r complications that c	aused the death				<u>717 Gre</u>	enPa	stur	es	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	011 01	otaun Woun	d to Head							Between Onset and Death
Examiner		or condition resulting in death)		consequence o								
Market Comments of the Comment	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to /or as s	consequence o	f).							
	mine	cause Enter Underlying Cause (Disease or injury that initiated		consequence o	· ().							
cuted nd nransit	Examiner	events resulting in death) Last		consequence o	f):							
enec an a		UNPENDED	X AMENDED			10.10= 777						
tox 68760, eath certificate be ex e attending physician for use as the burnal	Medica	IF FEMALE:	23c If yes,	#/, pertH outcome of preg	, G863, 1	/9/0/ TT			23d	. Date of d	elivery	
687 ertific ding p	sician/M	23b Was decedent pregnant in t past 12 months?	I Live t	oirth ant at time of de		tal death	B Ectopic	oregnancy		Month	Da	y Year
Box 68760, a death certificate be the attending physic of for use as the bur	ysic	1 Yes 2 No 9 Ur	7		earn 5 Otl	her (Specify)						
O. B. at the de d by the tached f	Phy:	Part II. Other significant condi	tions contributing to	death but not re	esulting in the u	ınderlying caus	e given in Part	23e D	d tobacco u	use contrib	ute to th	ne cause of death?
Division of Vital Records, P.O. Box 68760, within 24 hours after death. The law requires that the death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	d by							1	Yes 2	No 3	Proba	bly 4 Unknown
cords, law requir has been s	Completed							24a W au	as an itopsy			opsy findings available mpletion of cause of
Recc The lavicate ha	om								erformed?		ath? Yes	2 No
Vital Recysician: The his certificate director, page	BeC	25. Was case referred to medica examiner?				26. Pla		Check only one)				
of Viting Physic ing Physic After this	Tol	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatient 28b. Time of h			Nursing Home 5		nce 6 🗸		Scene
Division of pital or Attending Plous after death. neral Director: After filled in by the funeral	ion:	1 Netural	28a. Date Month FOUND	Day,Year)	FOUND:		njury at Work? Yes 2 ✓ 1	28d. Descri Subject s		ry occurred	3	
isic	ertification:	2 Accident Inve	Stigation Jan 1, 2	007 e of Injury - At h	1015 hrs ome, farm, stree				n (Street ar	nd Number	or Rura	Route Number, City
Divis Hospital or A 24 hours after Finneral Dire tely filled in b	ertif		ald not be ermined (Specify)	Other (driv	reway)			or Tow	n, State)			ordova, MD
Division To the Hospital or Attent within 24 hours after death To the Finneral Director: completely filled in by the	al C	29a Certifier	hysician: To the bes	at of my knowled	ge, death occur	red at the time,	date and plac	e, and due to the c	ause(s) and	d manner a	s stated	i
To the Hos within 24 h To the Fin	Medical	2 🛡	aminer:On the basis and manner s		nd/or investigat			urred at the time, d	ate and pla	ce, and du	e to the	cause(s)
	Σ	29b Signature and title of certific	ier /	//			nse number					h, Day, Year)
		<u> </u>	M. //	t		0.0	C.M.E.		Janu	uary 2, 2	:007	
6		30. Name and address of derso Jack Titus MD. De	n who completed cau puty Chief Medi	,	,	n Street, B	altimore. M	ID 21201				
	tate	31 Date filed (Moeth Pay Year	32 R	egistrar's Signat		R n						
Regis	trar	OMIY U J	LUUI PLES	your S	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	18.1						

		•	For Amend #20b Pe	State of Maryland / Depa er FH G863 1/04/06 Cer	rtment of Health and N Tifficate of Death	fental Hygier	ne 007	00029		
	Dhuaisia		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death		
	Physicia /Medic	al	Howard		Ellis		2 2007	3:05 AM		
	Examin	er	4a. Facility Name (If not institution, give st	16	4b. City, Town, or Location of Death		4c. County of Death N/A	1		
			Baltimore VA Medi 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign		
	Funeral Director			M 2□F 86 Yrs.	Months Days Hours Min.	July 9, 19	720 Ma	aryland		
	ט	İ	Usual Residence of Decedent					10d. Inside City Limits		
	arytar show	_	10a. State 10b. County	ndel Pasadena				1 ☐ Yes 2 ♣No		
	Sa-f	Director	Maryland Anne Arus	nder rasadena	10f, Zip Code	100	Citizen of What Co	into/?		
	with t	5	8109 Whites Cove Ro	oad	21122	.09.	10g. Citizen of What Country? U.S.A.			
	ns 23	Funeral		2 Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,		
92	filed within 72 hours after death with the Maryland Hygiene. briter than "natural", or Itams 23a or 28a-f show ent, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☑ Married	1 PYes 2 No if Yes, Give	f Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ᠌ No Specify:	Hican, etc.)	Specify: UI	nite		
Ö	hours tura!	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	dent's Usuaf Occupation	166	. Kind of Business/			
15	nin 72 n na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	kind of work done during most of work DO NOT use retired)	king				
212	d with giene er the	E	12	N/A HV	AC Technician		Griffith	Consumers		
Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	D E11		e (First, Middle, Mai		ailey		
yla	Men Men Marke Marke	ပ	Thomas	D. E11		nl Pouto Number Ci				
Mar	12 sh h and 7 ls rr traur		19a. Informant's Name/Relationship (Type Betty S. Ellis (Wi.		ng Address <i>(Street and Number or Ru.</i>) Whites Cove Road					
ē,	Heali Heali tam 2 tam 2		20a. Method of Disposition	20b. Place of Dispo			. Location - City or			
ē	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		9/ 06 Ar	lington V	irginia		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If tam 27 is marked other than "natural; or ttams 23a or 28a-f show any injury or other traumatic event, to Medical Examinar must be notified at once.		21. Signature of Funeral Service Licenses	l IV	Name and Address of Facility IcCully—Polyniak F 3204 Mountain Road	uneral Ho Pasadena	me, P.A. . Marvlan	d 21122		
			23a. Part Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do not ent				Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Complication	ne of Diabetes			Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):						
	LXamilie	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
V	nsit	mlne	Cause (Disease or injury							
oʻ	icate be executed physicien and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):						
8760,	ite be iysicie ne bur	Ical	L d.							
9		Med	IF FEMALE:							
Вох	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of del Month	ive <i>r</i> y Day Year		
P.0.	he de / the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Pregnant at time of death 5⊆ 9□Unknown	Other (specify)					
	that ned by deta	y Ph	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
rds	quires nn sign uld be	q pa	Prostite Gincor,	Dementia		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Etnknown		
ဝ၁	aw re	plet				24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of		
Ě		Com				performed 1 ☐ Yes 2 🚾	d? death?			
/ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			th (Check only one)				
d	Physiclan: r this certific ral director,	D .	1 Yes 2 No P	ospital: 1 ☑Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time o		ome 5 Residence 28d. Describe how		cify)		
L _O	ding h. After tuner	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred			
Division of Vital Records,	Attending ar death.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,		
Ö	ital or rs afte ral Dir led in	Cert	Titilious	Building, stc. (Specify)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place execution, in my opinion, death occurrence.	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)		
	withi To #	×	29b. Signature and title of sertifier		29c. License number	29d	. Date signed (Mont	h, Day, Year)		
•			The A	MO	P19694		Jan 2,	2007		
	(ox)		Q'1. C V.1	mpleted cause of death (Item 23a) (Type,		AAA	21201			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	reene Su Callin	one IVIU	201			
	Registi		JAN 0 4 20	07 Deserve A A	and D					

			1 - For Amend Item 7 Registrar	State of Marylan per FH, G863,	01/05/07df Certifica	nt of He te of D	alth and N eath	Mental Hygie	en@ () () 7	00030
	Physici /Medic		1. Decement's Name (First, Middle, Last)	nk				2 Date of Death Month	3,2007	3. Time of Death
	Examin Funeral Director	er	5. Social Security Number 6. Sex 1□	Ju-sizy & Reho	26Ctr. 130	Altmi er i Year	ocation of Death Ore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept25,	4c. County of Deat 9. Birt. 20 1918 Loc	nplace (State or Foreign untry) k Haven, PA
	within 72 hours after death with the Maryland ane. than "naturel", or Iteme 23a or 28a-1 show the Medical Examination at the motified at	ector	Usual Residence of Decedent 10a. State 10b. County Md • Balti		y, Town or Location Pikesvill					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the 23a or 2	Funeral Director	10e. Street and Number 4201 Lowell Dri 11. Marital Status	2. Was Decedent Ever in U.	2	ip Code 1208	panic Origin? (Sp	Decify Yes or No-	U.S.A. 14. Race - Ame	rican Indian,
9000	nours after ourel, or iter	d by Fur	1 Never Married 2 Married 3 Widowed 4 Novorced	Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	1 □ Yes	2 ¼ №	Specify:		Specify: Wh	ite
21215-0036	permit. Pages 1 end z should be tiled within 7z hours after death with the Marylan Department of Health and Mental Hygiene. Integrately, or terme 23a or 28a-f ehow montainst if them 27 is marked other than "naturely, or terme 23a or 28a-f ehow eny injury or other treumatic event, the Madical Exeminat must be notified at once.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	ation completed) College (1-4or 5+) 4	16a. Decedent's Us (Give kind of w life. DO NOT Registe	ork done dui use retired)	ring most of wor	king	School N School N City of	· ·
Maryland	should be filed nd Mental Hygi marked other umatic event,	To Be (17. Father's Name (First, Middle, Last) David Murray			I	sabel			
	1 end 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Typ. Jon R. Frank 20a. Method of Disposition		19b. Mailing Address 8830 Lib Place of Disposition (Note that the semantary or a	erty	Rd. Ra	ndallst	OWN, State, 2 OWN, Md. Oc. Location - City or	21133
Baltimore,	permit. Pages Department of h Important: If Ite eny Injury or of once.		1 ⊠ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Res	stHavenMe	mPark and Address	of Facility KaC	2007 L zorowsk	och Have i Funera	n, Pa. 1 Home,PA
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deatle cause on each line.					imore, M	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	uence of):	72				y-ears
,760,	te be executed ysician and eburial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
Division of Vital Records, P.O. Box 68	Attending Physicien: The law requires that the death certificate be executed rideath. ector: After this certificate hes been signed by the ettending physician and the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 goonths? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3 □Ectopic				23d. Date of dea	ivery Day Year
ords, P.	equires that en signed b	by	Part II. Other significent conditions con	tributing to death but not res	ulting in the underlying	cause given	in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
al Reco	i: The law ricate hes be	Completed	anemia					24a. Was an autopsy performe 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No
<u> </u>	sicien certif rector	Be	25. Was case referred to medical examiner?	ospital:		Other	1.6	th (Check only one)		
ion of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury a Work?	4 Nursing H	ome 5 ☐ Residen 28d. Describe how	ce 6 Other (Specially) occurred	cify)
Divis	itel or Atte ars after de rel Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	(y)			City or Town,		
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	edical	(Check only 2 Medical Exeminates)	ician: To the best of my kno ler: On the basis of examina and manner stated.	ition and/or investigation	n, in my opin	nion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	my hu	20	9c. License r	1-391		a. Date signed (Monti	3
	ŋ	10	30. Name and address of person who co	mplete Lausé of death (Iten 3 20 Sens m 32. Registrar's Signa	Avenu	e, 13	altimo	re Man	yland	75515
	Sta Registr		JAN 0 5 2	007 Alexan	b. Soul					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:59 AM FRAME GWEN Januar 2007 /Medical 4b. City, Town, or Location of Death 4c. County of De 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Washington Modical Center Glen Burnie Anne Arunde If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 😿 F 70 160-26-8443 Director D1/16/1936 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No ANNE ARUNDEL PASADENA Director MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21122 U.S.A. 692 D. STREET Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: λq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** SECRETARY TO PRINCIPAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be F₀X NODLER ROSE **EDWARD** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 692 D. STREET - PASADENA, MD 21122 MARTIN FRAME / HUSBAND 20b. Place of Disposition (Name of competery, crematory or other place)
ANSHE EMUNAH
AITZ CHAIM 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State |BALTIMORE, MD D1/03/2007 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Aven 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Part1. Enter the disease, or complications, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a construence of): disease or condition resulting in death) /Medical Examiner ute myocar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit be executed ordnary 61 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 45101 1 | Yes 2 | No 3 | Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1□ Yes 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

Allen H. Schaeffer Baltimore Washington Medical Center Glen Burnie, Md. 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifie

JAN 0 4

30. Name and address of person who completed course of death (Item 23a) (Type, Print)

32. Péristrar's Signature

DHMH 17 Rev 1/2001

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00015685

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year \mathcal{B} . 02 1850 PM 2007 corac 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Rockville Montgomery HOTAL Grove ventist If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 M 2 □ F 1918 579-10-0677 88 June 4, Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1⊠Yes 2 No Maryland | Montgomery Garrett Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10909 Clermont Avenue 20896 United States . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Davidson Griffin Edith Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard G. Griffin / Son 6886 Garland Lane, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility bert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia one Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

xaminer requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

the Medical

7 is marked other than traumatic event, the Me

1 and 2 should be fill Health and Mental H tem 27 Is marked ott

.. Pages 1 and ment of Health and

Department of Important; If it any Injury or o

Director

Funeral

Completed by

Be

ပ္

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Physician:

or Attending

Hospital

burial-tra physician the signed b I b**e** deta

director After death. within 24 hours after death **To the Funeral Director:** сотрletely filled in by the f

1	_	
	Physician/Medical	
١	l by	
	Sompleted	
ı	ro Be	8
1	8	
1	ĭ	t
1	Ë	ı

Medical Certificati

Brandon

31. Date filed (Month, Day, Year)

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Medical

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 5

a

JAN 0

10

State Registrar

000 64029

Drive Rockville, Md

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month GREENBERG JANUARY HENRY 1050 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOS PITAL BALTIMORE NORTH WEST RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, Year! 01/28/1929 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 □ F 213-28-3348 77 Yrs MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or itame 23a or 28a-f shov the Medical Exeminer must be notified at MD BALTIMORE RANDALLSTOWN 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9032 MEADOW HEIGHTS ROAD 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after dall Hygiene.

Other than "natural", or itam Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0.12) College (1-4or 5+) EXAMINER SOCIAL SECURITY ADMIN. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event QING. Be GREENBERG FREDERICK **ESTHER** HAMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA GREENBERG / WIFE 9032 MEADOW HEIGHTS ROAD - RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) ZION 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LIBERTY PARK SHAAREI 01/04/2007 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★○No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 2 Medical E one) 29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Ovetson ans. 00059736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD MARYLAND DEBORAH RAMO ALLSTOWN 5401 COURT MOZT AM 040 31. Date filed (Month, Day, Year) 32. Restrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year 7:25 AM **Physician** MICH Corgon 2007 ARUATV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8805 Fearne Ave. Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Months Days 1 M 2 □ F 216-18-4274 83 Yrs Director April 16, 1923 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show if Heelth and Mental Hygiene. Item 27 Is marked other then "natural", or Itema 23s or 28s-1 ehov other traumatic event. It a Modical Examinar must be notified at 1 Yes 2 No MD Baltimore Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8805 Fearne Ave. 21234 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) VWR Scientific Clerk N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Gordon, Jr. Emma L. Callahan မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Gordon, IV- Son 13911 Manor Rd. Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ot ong injury or ot Lorraine Park Ceretery 1-6-2007 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 21. Signature of Juneral Service Licenses 8800 Harford Rd. Parkville, MD 21234 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final CDAGESTIVE rico. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner arlery discase coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 2 ER/Outpatient 3 DOA this hours efter death. Ineral Director: After this y filled in by the funeral di 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24916 2007 30. Name and addless of person who completed cause of death (Item 23a) (Type Print)

10 1 1 2 2 M.V. 5601 Loch Rayen h Baltimore Mary

State Registrar 31. Date filed (Month, Day, Year)

32. Registgar's Signature

		•	1 - For State Registrar	State of Mai	ryland / [rtment tificate			nd M		jiene eg. No.	007	00	035		
	Discosia:		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	Day	Year	3. Time o			
	Physici /Medio		Hildegard M. Gros								Jan.	2	2007) A. M		
	Examin	er	4a. Fecility Name (If not institution, give :						ocation of	Death		_	nty of Death		·+		
			6 Manor Knoll Cou		(In yrs. last bir	rth day)		dwin	If Under 24	4 Hrs.	8 Date of Birth			e Coun			
	Funeral Director			_	0 =	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sept.		1 Bor	place (State intry)	Germany		
			Usual Residence of Decedent								sept.	21 , 131	T DET	TTII, C	CIMATIY		
	yland		10a. State 10b. County		10c. City, Tow		cation							10d. Inside (
	e Ma	cto	Maryland Baltimor	e County	Baldwi	ın							1 🗆 Yes 2 🔯 N				
	ih th	Oire	10e. Street and Number				10f. Zip					log. Citizen		intry?			
	ath w	rai	6 Manor Knoll Cou			10		21013					rmany				
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be muited at ance.	y Funerai Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							E	14. Race - American Indian, Black, White, etc. Specify: White						
Ö	hours urs!	d b	3 ☑ Widowed 4 □ Divorced	Year or Dates:	160	Doore	lent's Usua	I Occupat	ion			16b. Kind of	Business/I	ndustry			
7	n 72	Completed by	15. Decedent's Edu (Specify only highest grad	completed)		(Give	kind of wor OO NOT us	k done du	iring most	of workii	ng gr	TOD. KING O	003111033211	ildustry			
12	withi Bne. thsc	mo	Elementary/Secondary (0-12)	College (1-4or 5+ N/A) 5	Sale	s Per	son				Sales					
b	Hyg othe	BeC	17. Father's Name (First, Middle, Last)	11/11					18. Mother	's Name	(First, Middle,	Maiden Surr	name)				
<u>la</u>	uld be Aenta rksd tlc sv	To B	Herman Kogel						Adel	hei	t Unknow	wn					
Maryland 21215-0036	and he ma	0.9	19a. Informant's Name/Relationship (Ty								Route Numbe						
	and 2 selith n 27 i		Mrs. Karin Heckman) (Daughte					Cour		aldwin,						
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	ernoval from State	20b. Place o	ry, cren	natory or of	ther place	, 1	1//	ate	20c. Locatio					
Ĕ	Pag ment ant: ury c	1 3	4 □Donation 5 □ Other (Specify)		Evans					14	101	Forest	HIII	, Mary	riand		
Baltimore,	Deprint Import		21. Signature of Funeral Service Licens	**************************************		Pe 23	Name and acefu 25 Yo	d Address il Al ork R	of Facility terna oad T	tive imo	es Fune: nium, Ma	ral&Cr arylan	emati d 210	on Ctr	. P.A.		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	JA_		er the mode	e of dying	, such as c	ardiac o	r respiratory ar	rest,		Approximation Interval But Onset and	etween d Death		
8760,	icate be executed physicien end the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a d.	consequence	of):									7		
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome o 1⊡Live birth 2 4⊡Pregnant at t 9⊡ Unknown	Fetal death		Ectopic pro						Date of deliment	very Day	Year		
Vital Records, P.	es the gned be de	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting	in the u	nderlying ca	ause give	n in Part I.		23e. Did to	es 2.50		the cause of			
Ö	w requir been si should	Completed									24a. Was	an 24	b. Were au	topsy finding	s available		
Re	The lay ate has page 2	Ĕ									autop	med?	death?	ompletion of 2 No	cause of		
tal		0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	28No	1 🗆 Yes	2 NO			
<u> </u>	Physician; this certific ral director,	OB	examiner?	lospital:	t 2 ER/O	utpatien	t 3 DO	Othe			ne 5 Resid		Other (Spec	ufy)			
1 0		Ë	27. Manner of Death	28a. Date of Injury (Month, Day	28b.	Time of		8c. Injury Work			28d. Describe h			,,			
<u>ö</u>	본족폭호	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(worm, bay	/ GAI/	injuly	М		es 2 □N	10							
Division	9 4 4 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, for (Specify)	arm, str	eet, factory	, office			28f. Location (S City or Tow	itreet and Nu m, State)	ımber or Ru	ral Route Nu	mber,		
	To the Hospitel or within 24 hours after To the Funersi Dit completely filled in	edical (sician: To the best of ner: On the basis of and manner stat	examination at)(s)		
	To the within 2 To the complex	Me	29b. Signature and title of certifier	0 /	1) /:	^		. License		~ ~		29d. Date sig					
	/		4 Justano	Y. Cus	tlw M	1.[]		DI	451	03		1-	2-	0+	•		
	b		30. Name and address of person who co	ompleted cause of de	ath (Item 23a)	(Type,	Print) G	en	tro,	Au	2214	TIM	MIUM	210°	93		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	20	-	a.e		1							

ORIGINAL

Division or Vital Records, P.O. Box 68760.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician HENRIETTA** HANDLEMAN JANUARY 2007 10:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Hours 1 □ M 2 □ F 215-18-7977 85 06/01/1921 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MD BALTIMORE BALTIMORE 1 ☐ Yes 2**/**☐ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7920 SCOTTS LEVEL ROAD 21208 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLEMIS ROBINSON BERTHA **JEAN** GOODMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID HANDLEMAN / HUSBAND 7920 SCOTTS LEVEL ROAD - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHIZUK AMUNO CONG. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 01/04/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Part 1. Friter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate 23a, Part1. Immediat Cause (Final disease of andition resulting in death) ATHEROSCIENTIC CARDIOVASCILAR DISTALE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔣 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15.5. RAO. PI.O 10 43462 JANVAR 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 - S - 12 - 12 - 12 - 12 #108 OLD COUNT 210 51133 5400 nd NANDALLITOUR 31. Date filed (Month, Day, Year) 32. Distrar's Signature State JAN 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:45 PM HICKS JANUARY BERNIE 7007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

OA-AA-1939 HOPKINS Der 6. Sex HOSPITAL THE JOHNS 1 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 242-54-8168 Usual Residence of Decedent 6 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Minera 1 Yes 2 □ No VΑ **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worke ath . Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip code) 19a. Informant's Name/Relationship (Type. Print) tinksburg 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State tark 101-06-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License tuneral ndallstown MD 2/133 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part1. Enter the shock, or heart Immediate Cause (Final disease or condition resulting in death) Physician Collapse 10 minutes Cardiovascular /Medical Due to (or as a consequence of): Examiner erreardial Sequentially list conditions, if any leading limit and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of). Examine ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Lung Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1,2007 - MEDICHL DOCTOR RES-000 JANUARY Macy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

HORTH WOLFE STREET, BALTIMORE, MD 21287

TRACY (WANNER TOHUS HOREINS HOSPITAL 600 31. Date filed (Month, Day, Year) . 82. Registrar's Signature

1300 Q 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 37 1, 2007 4c. County of Death Juanita anuare Ann HENSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA paryland Gieneral Hospital timore Year If Under 24 Hrs.

Pavs Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2\ F 213-36-6044 Md Director 2,1941 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at Director Yes 2 No Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit, Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or may Injury or other traumatic event, the Medical Examiner must be 1 once. 1100 Pennsylvania - Hre 21201 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland 9 th Hospital Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rubie Nathan Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henson Red Haven Bd Baltimore Md Mubic 4203 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-8-07 4 □ Donation □ Other (Specify)

21. Signature □ Funeral Service License Cometary 22. Name and Address of acility Chatman - Harris Funcay Home 5240 Ruisterstown Rd Baltimore Md 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (First **Physician** DSig disease or condition resulting in death) /Medical Due to (or as a consequence of): gan failure Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural I Director: A within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 2 Medical Examiner: 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. No me and address of person who Rybrd General nomas 31. Date filed (Month, Year) 32. Régistrar's Signature State 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar	•	artment of H rtificate of I			ene g. No. 200	7 00039
	B		Decedent's Name (First, Middle, L.)	.ast)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		BEVERLY		Hu	BBUCH		JANUARY	01,200	A P C C I
) }	Examin		4a. Facility Name (If not institution, g			1	r Location of Death		4c. County of De	ath
1			THE JOHNS HOPK				NORE CIT	-		
	Funeral			. Sex 7. Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (irthplace (State or Foreign Country)
	Director		578-52-6365 Usual Residence of Decedent	66	115.			June 13,	1940 Was	shington, D.C.
	land the		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -f sho ied a	ğ	MD Prince	George's L	aurel					1 □ Yes 2/□XNo
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	3a ol		6119 Brooklyn E	Bridge Road		2070	7		USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
2-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☑ No		riicari, etc.)	Specify: W	
ŏ	72 ho	Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occup	ation	ring 1	6b. Kind of Busines	ss/Industry
215	thin 7 e. an "r Med	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or work	arig		
7	ed wi ygien ter th	S	12th	Ø	De:	li Clerk			Giant F	Food
Maryland 2121	be file tal H d oth even	Be	17. Father's Name (First, Middle, La.	st)			18. Mother's Name	e (First, Middle, M	faiden Surname)	
Z a	should be and Mental smarked o	ို		nith	1		Thelma			
<u>a</u>	12 sh h and 7 Is n traun		19a. Informant's Name/Relationship						City or Town, State	, ZIP Code)
	ges 1 and 2 should it of Health and Men If Item 27 Is marke or other traumatic		Christopher D. H. 20a. Method of Disposition			9 Brookly sition (Name of matory or other place			urel, MD 20c. Location - City of	20707 or Town, State
altimore,	Pages net of I int: If Ite		1 ☐ Burial 2 🖺 Cremation 3	nemovariiom state		<i>matory or other plac</i> ndel Crem		5, 2007	Odenton,	· —
≝	iit. P.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lid	chy)				•		Home, P.A.
Ba	permit. Page Department of Important: If any injury or	10	Damerot	A (MOI	103 3	l3 Talbot	t Avenue,	Laurel,	MD 2070	·
r.			23a. Part1. Enjer the disease, or co shock, or heart failure. List on	mplications that caused the dea ily one cause on each line.	ith. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATOR	RY FA	ILURE				2 days
	/Medical Examiner		resulting in death)	Due to (or as a consec				1		0 !
		<u>.</u>	Sequentially list conditions.	b. METASTATI		CINOMA	DF UNKNO	MN AKIW	AKY	2 weeks
	ist of te	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PNEUMONI	• •					2 weeks
- F	ificate be executed g physician and as the burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a conse						
68760,	siciar siciar buri	Sal		d						
	ificate g phy as the	edical		0.					1	
Box	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet		∃Ectopic pregnancy	.,		23d. Date of c	delivery
ω.	w requires that the death cer been signed by the attendir should be detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of		Other (specify)	у		Month	Day Year
Ö	at the by th tache	hys	9 □ Unknown	9DONKHOWN						
Š,	es tha	by F	Part II. Other significant conditions	s contributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ž	equir en si ould I			,	-			1 ☐ Ye	s 2 No 3 □	Probably 4 ☐Unknown
ပ္ပ	has be ge 2 sh	Completed						24a. Was ar	v prior t	autopsy findings available o completion of cause of
<u>~</u>	The ate h page)om						perform 1∐ Yes 2	ned? death 2 X No 1 ☐ Y	? _ /
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					th (Check only one	9)	
2	hysi this c	은	1 ☐ Yes 2x No	Hospital: 1 Inpatient 2			4 Li Nursing Ho		nce 6 Other (S)	pecify)
ŭ	ing Phys After this funeral di	ion:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe ho	w injury occurred	
S	ttend death stor:	icati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	t be 380 Place of injury At h	nome farm et		Yes 2 □ No	20f Location (Str	mat and Number or	Rural Route Number,
Division or Vital Records, P.O.	after of Direction by	Certification:	4 ☐ Homicide determine	building, etc. (Spec	ify)	reet, factory, office		City or Town		narar noute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page			Physician: To the best of my kn	nowledge, deat	th occurred at the ti	me, date and place,	, and due to the ca	ause(s) and manner	as stated.
	e Hos 24 h e Fur	Medical		kaminer: On the basis of examin and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (Mo	onth, Day, Year)
	./		Rakhi No	aik, MD		RES -	000	-	JANUARY	01, 2007
	15		30. Name and address of person wh							
			RAKHI NAIK				EET, B	ALTIMOR	LE, MD &	112 05
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	de				
	Regist	al	JAN 0 4 20	UI PERSONAL PO	1	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 2, 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Charles Humes 2007 9:00 PM January /Medical 4a. Facility Name (II not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hampstead Carroll 2352 Harvey Gummel Road If Under 1 Year | If Under 24 Hrs. Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 □ F Months 76 April Maryland Director 218-26-0125 14,1930 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Hampstead Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or; 21074 USA. 2352 Harvey Gummel Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Topy / es 2 | No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🖫 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mass Transit Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician Administration 12 years vears permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If item 27 is marked other ti any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth S. Lansella Charles E. Humes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ed Humes son 741 Darlington Road, Darlington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 5, 2007 Hanover, PA. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease of complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 □ Yes 2 □ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 20b Signature and title of gertifie 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 1 2

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 0 4

32. Registrar's Signature

07-00058 Charlene Lorrain	e H		pe or Print in E tate of Maryland						egibl		7 0004
	!!	I-For State Registrar Amend #7&8	Per FH G86						Reg. No	200	
Physicia Medical Exami	111	Decedent's Name (First, Midd Charlyn Lal	Rayne Hyman					2. Date of D Month January	eath Day 2, 200	Year 7	3. Time of Death 2330 hrs
rama		4a. Facility Name (if not institution 1402 West Madison 1		er)		4b. City, Town, o	or Location o			c. County of Dea	hth
Funeral		Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Ye	ear If Unde	er 24Hrs 8 Date of	Birth (MM		arthplace (State or
Director		218-64-1601	1M 2XF	49	-50 - Yrs	Months Da	ys Hours	Min. 01-01/02	13-19 1/1957	Fore C	ountry) MD
any	-	Usual Residence of Decedent 10a State 10b. County		10c City, To	own or Loca	tion	÷				10d Inside City Limits
*	ō	MD			Balt	imore					1 XYes 2 No
oith the Maryland 23a or 28a-f show a potified at once.	Director	10e. Street and Number 1402 West Madison	Avenue			10f. Zip Code	21217	,		izen of What Co USA	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Decede				lispanic Orig	gin? (Specify Yes or		14. Race - Ame	erican Indian, 8lack,
er death	Funeral	Never Married 2 No	Armed Force 1 Yes vorced If Yes, Give Year	2X No		_		, Puerto Rican, etc.)		White, etc.	
ours afte atural"	d b	15. Decedent's Education (Spe	or Dates:	ompleted) 1	I6a. Deceder		ation (Give I	kind of work done	16b	Kind of Busines	an American s/Industry
36 in 72 h han "n dical Es	Completed	Elementary/Secondary (0-12)	College (1-4 c			nost of working life executive		,		Tide Wate	er
5-0036 iled within 7. Hygiene d other than	S	17 Father's Name (First, Middle	e, Last)				18.Mother	's Name (First, Middl	e, Maiden	Surname)	
2121: buld be fil Mental F marked	o Be	Charles M	1. Hyman, Sr.		19h Mailin	n Address (Stra	eet and Num	Marilyn A.			to Zin Codo)
MD 2 ad 2 shou lith and M n 27 is n aumatic	٥	Charlene L. Hyman			505	Gold Stree	et; Bal	timore, Mary		-	te, Zip Code)
more, Pages I and nent of Heal ant: If iten		20a Method of Disposition 1 8urial 2 X Crematio	n 3 Removal from		ace of Dispor ematory or of	sition (Name of c ther place)	emetery,	Date	20c.	Location - City	or Town, State
altime rmit. Pag spartment aportant: jury or ot	-	4 Donation 5 Other S		Met	ro Crem	Name and Addre	ss of Facility	01/10/2007		ltimore,	
Ba perm Depa Imp		Jennela	Jones			638 N. Gi	lmor St	Wylie E reet; Baltin			'-A 21217
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.				g, such as ca	ardiac or respiratory	arrest, sh	ock, or heart	Approximate Interval 8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscleroti Due to (or as a co		scular Dis	sease					Deali
d.	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of);							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):					-		
executed an and al-transit	ᇹ	Creme resulting in death, East	d								
e = =	ledic	UNPENDED IF FEMALE:	AMENDED 23c If yes, outc	nome of progra	2007				1 00	d Data of dalling	
Division of Vital Records, P.O. Box 68760, arther Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	23b Was decedent pregnant in t past 12 months?	the 1 Live birth		2 F		Ectopic	pregnancy	23	d. Date of delive Month	Day Year
Box death c	ysic	1 Yes 2 No 9 V Ur		at time of deat	n 5 0	ther (Specify)					
P.O.	by PI	Part II. Other significant condi	tions contributing to de	ath but not res	ulting in the	underlying cause	given in Pa				o the cause of death?
ds, Fequires								24a W	as an	24b Were a	autopsy findings available
ecor he law ate has t	Completed		_					pe	topsy rformed? s 2 🗸 N	death?	completion of cause of
tal R cian: T certifica ector, pi	Be C	25. Was case referred to medical examiner?	Hospital:		-		T-	(Check only one)			
n of Virting Physical After this funeral dir	2	1 Yes 2 No 27. Manner of Death	28a Date of I	njury 2	R/Outpatien 28b. Time of		Other ₄	Nursing Home 5 28d Describ		ence 6 🗸 Oth	er; Scene
ion (teath tor: A)	ation		(Month, Da nding estigation	y.Year)		1	Yes 2	No			
Division of Vital Records, pital and cauted properties of Attending Physician: The law requirements after death erral Director: After this certificate has been sifilled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Cou		Injury - At hom	ne, farm, stre	et, factory, office	building, et	c. 28f Location or Town		and Number or F	Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide 29a Certifier 1 Certifying F	Physician: To the best of	my knowledge	e, death occu	irred at the time,	date and pla	ace, and due to the ca	ause(s) ar	nd manner as sta	ated
To the Howithin 24 h To the Fur	Medical		aminer: On the basis of e and manner state	xamination and	d/or investiga		on, death oc	curred at the time, da			
	<	29b Signature and title of certification of the Signature Blass	ell Mix	-			.M.E.			Date signed (Minuary 3, 200)	
H		39 Name and address of perso Melissa Brassell, MD				Penn Street,	Baltimore	e, MD 21201			-
	ate	31 Date filed (Month, Day, Year	4 2007 32. Redis	trar's Signature	Ro A	10000					
	Registrar JAN 0 4 2007 P										

Name and address of person who completed cause of death (Item 23a) (Type, Print

title of certifier

29d. Date signed (Month, Day, Year) JANUARY 2, 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

GEORGE WEINER, M.D. HARFORD ROAD, PARKVILLE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar 29b

State of Maryland / Department of Health and Mental Hygier ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 1,2007 Year **Physician** 10:25p м Jan. /Medical <u>Helen M. Haines</u> 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Reisterstown FutureCare Cherrywood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 1911 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 M 2/X 217-03-3317 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "nature!, or Items 23e or 28a-1 show way futury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XXNo Director Baltimore Reisterstown Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21136 12020 Reisterstown Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X. Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Gill Bessie Turnbaugh (Unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Step-Daughter 33 Jury St., Highspire, Pa. 17034 Margaret Dengler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet.Cem.Jan.8,2007 Owings Mills, Md. 21. Signature of Fun ral Service Un of ee 22. Name and Address of Facility 11605 Reis.Rd. Eckhardt FuneralChapel,P.A.OwingsMills,Md 23a. Part 1. Exfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** unnon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien end for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year signed by the eld be detached f 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown been signated Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate hes b autopsy performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: : After this certification funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 10 Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury al Work? 28d. Describe how injury occurred 5 Pending death. М 1 Tes 2 No investigation 2 Accident after death Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address 1838 Geene Tre son who completed se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State JAN 0 Registrar

-	0	0	1	9
1.1	11		1	1
-	- U	U	100	E,

				State Registrar		•	Certifica	te of l	Death		Reg. No	2001	00044
		Physicia		1. Decedent's Name (First, Middle, Dr. Frederic		drich	, Jr.			2. Date of De Month Januar	Da	ay 2007	3. Time of Death 8:10 A M
		/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City	y, Town, or	Location of Dea			. County of Death	0,10
-	À			Stella Maris	Hospice			To	owson			Balti	more
	100	Funeral Director		5. Social Security Number 219-18-3167 Usual Residence of Decedent	5. Sex 7. Age ↑ M 2 F	(In yrs. last b	Yrs. If Und Months	er 1 Year S Days	If Under 24 Hi Hours Mi		ay, Year,) Cou	place (State or Foreign ntry) yland
		land t	}	10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
		ne Mary 8a-f sho otlfied a	ctor		imore			ther	<i>r</i> ille		10 0		1 □ Yes 2 X No
		ath with the 23a or 2	Funeral Director	10e. Street and Number 21 Oakridge Cou					21093		Ur	nited Sta	ites
a.m.	900	Irs a	þ	11. Marital Status 1 □ Never Married	12. Was Decedent Ev Armed Forces? 1V Yes 2 No If Yes, Give Year or Dates:	Korea	1 □ Yes	2 X No	Specify:	(Specify Yes or No erto Rican, etc.)			etc. nite
਼ ਲ	5	72 h 'natu dical	ete	15. Decedent's (Specify only highest	s Education grade completed)	16	Sa. Decedent's Us (Give kind of v	sual Occup vork done	ation during most of w d)	vorking	16b. k	Kind of Business/Ir	dustry
8:10	21215-0036	d within giene. ir than " the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Pedia					Medical	
	פ	al Hy othe	Be C	17. Father's Name (First, Middle, L	ast)					ame (First, Middle	e, Maidei	n Surname)	
2006	aryland	Menta	To	Frederick J. H						Leuers			
, 20	Mar	d 2 sho th and th and traum		19a. Informant's Name/Relationsh Eleanor Heldric			-					or Town, State, Zip MD 21093	,
1 2,	altimore,	es 1 an of Heal item 2		20a. Method of Disposition		20b. Place	of Disposition (Natery, crematory of	lame of	1	Date		ocation - City or T	
AR	ij	Page nent ant: If ury o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify)	West	Arundel					enton, MI	
JANUARY	Balt	permit. Depart Import any Inj		21. Sgraue of Funer Service	DOF	Work						ral Home, tus, MD 2	
	t	×	V	6a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused t nly one cause on each line	he death. D	o not enter the m	ode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CEREBRO Due to (or as a		AR ACCID be of):	ENT				-	
		Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequenc	ce of):						
	60,	death certificate be executed e attending physician and ed for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequenc	ce of):						
	68760,	ificate g physi	Medical		d								
HELDRICH	O. Box	0 0 0	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal dea			у			23d. Date of deliv Month	rery Day Year
HE	ď,	requires that the een signed by th	by Ph	Part II. Other significant conditio	ns contributing to death but	not resulting	g in the underlying	cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
CK	ecord	equire	ted t							_ 1 _	Yes 2	2□No 3□Pro	bably 4XJUnknown
FREDERICK	α	e la has je 2	Completed							24a. Wa: - auto peri 1∏ Yes	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
RE	Vital	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical					26. Place of D	eath (Check only		10 10103	20110
124		Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/0	Outpatient 3 ☐ [DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	sidence	6 X Other (Spec	fy) HOSPICE
	on or	ttending Ph Jeath. :tor: After th the funeral		27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident investig.	28a. Date of Injury (Month, Day	Year) 28t	b. Time of Injury M	28c. Injur Wor	ryat rk? Yes 2 □ No	28d. Describe	how inju	ury occurred	
	Division	or A fifter (Direct in by	Certification:	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determin	ot be 28e Place of injur	y - At home, (Specify)				28f. Location City or To	(Street a	and Number or Rui te)	ral Route Number,
		Hospital 24 hours a Funeral I etely filled	Medical C		Physician: To the best of examiner: On the basis of and manner stat	examination							
		To the within 2.	Me	29b. Signature and title of certifier	The state of the s	-	2	29c. Licens	se number		29d. D	ate signed (Month	, Day, Year)
		->-0			/			1)1	4372	1		1/2/0	7
		127		30. Name and address of person v	who completed cause of de	ath (Item 23a	a) (Type, Print)						
		100		DR. TARIQ MAHMO	OOD 2300 DUI		VALLEY R	D. 1	TIMONIUN	MD 210	93		

DHMH 17 Rev 1/2001

Registrar

8:10 a.m.

			1 - For State Registrar	State o	of Marylar		artment of H		Mental Hyg	iene () ()	7 00045
H	Physici	an	1. Decedent's Name (First, Middl	e, Last)					2. Date of Deat Month	Day	3. Time of Death
	/Medic		Viol			vusich			January	1, 2007	
	Examir	er .	4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or		ıth	4c. County of	
			Pickersgill 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	ISON If Under 24 Hr	S. 8 Date of Birth		imore 9 Birtholace (State or Foreign
	Funeral Director		218-05-3092	1 ☐ M 2 💢 F	92		Months Days	Hours Mir		^{Year)} 19.1914	9. Birthplace (State or Foreign Country) Maryland
	D		Usual Residence of Decedent						, ragas o		
	show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	Ba-1	ecto	Maryland N/A			Baltim	T				
	with the	Dİ	10e. Street and Number				10f. Zip Code	4	1	0g. Citizen of Wh	
	heath	era	6612 Birchwood		edent Ever in U	J.S. 13. V	2121 Vas Decedent of H		Specify Yes or No-	U.S.	- American Indian,
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, if a M-circal Examiner must be mailtied at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Fried 1 ☐ Yes	orces? 2 X No ive	'	f Yes, specify Cuba □ Yes 2☐ X No	n, Mexican, Puè Specify:	Specify Yes or No- rto Rican, etc.)	Black, Specify:	White, etc.
Ö	72 ho	Completed	15. Deceden	t's Education st grade completed		16a. Deced	lent's Usual Occup	ation		16b. Kind of Bus	iness/Industry
21	thin 7	npie	Elementary/Secondary (0-12)		1-4or 5+)	life. L	kind of work done of OO NOT use retired))	orking	Baltimor	•
2	filed wi Hygien other th ant, It o	Col	12			Admin	istrative				Schools
ğ	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, tre M.	Be	17. Father's Name (First, Middle,					18. Mother's Na	ame (First, Middle, I)
3	should be nd Mental marked o	P_0	Robert 19a. Informant's Name/Relations		nan	10h Mailie	- Address (Chrost	and Alicenters of	Anna	Fadum	
Maryland	d 2 sl th an th an traur								Rural Route Number		laryland 21085
9	Health tam 27 l		Wayne Ivusich 20a. Method of Disposition	1 3011	20b.	Place of Dispo	sition /Name of				ity or Town, State
Baltimore,	t. Partmer		1 Buriai 2 Cremation Donation 5 Other (S	pecify)	State DU	demoria	Valley Tardens	T-T-		Timonium	
Ba	Depa Impo any ir		Dung	Hagan			1050 York	Road	Towson,	Maryland	
No. of the last	Priysician /Medical Examiner	_	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	each line. 7 As donsec	guence of):	er the mode of dyin Les for	. 0	ac or respiratory arre		Approximate Interval Between Onset and Death
8760,	death certificate be executed a attanding physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last	G	(or as a consec						
O. Box 6	death certif a attanding ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No	1 Live	itcome of pregn birth 2 Feta nant at time of c	al death 3 □	Ectopic pregnancy Other (specify)			23d. Date Monti	
rds, P.	w requires that been signed t should be deta	by	Part II. Other significant condition	ons contributing to c	leath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		ute to the cause of death?
Vital Records,	The far ate has page 2	Completed							24a. Was ar autops perform 1 □ Yes 2	y prin	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \)
Zi.	Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Othe	_	ath (Check only on		
ō	Phys r this ral dii	1: To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	3 DOA	4 Nursing	Home 5 Reside		
Division of	ttanding I death. stor: After / the funer	Certification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	g (Mor	oth, Day Year)	Injury		(? Yes 2 □ No			
Ω	ital or Attano urs after deatl ral Director: llad in by the		4 Homicide determ	ined 289. Place build	ing, etc. (Speci	fy)	eet, factory, office		City or Town	, State)	or Rural Route Number,
	To the Hospital or Attanding, within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	Medical	(Check only 2 Medical one)	and mar	e best of my kno easis of examina iner stated.	owledge, death ation and/or inv	estigation, in my or	oinion, death occ	e, and due to the ca curred at the time, da	use(s) and manrate and place, and	ner as stated. d due to the cause(s)
ŀ	To To t	2	29b. Signature and tile of certifie	Long the	ly,	mo	D 2				Month, Day, Year) 7 3,2007
1	5		30. Name and address of person	who completed cau	6701		hales	St. Ba	lfo-md	2120%	r
	Sta Registr	- 4	31. Date filed (Month, Day, Year)	2007	Registrar's Signa	ature Apa	W.				
DH	MH 17 Rev 1/2	201		4		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** SINC FOOS /Medical 4a. Facility Name (If not institution, give street and ity, Town or Location of Death 4c. County of Death Examiner -1m0 If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 ☑ F Yrs 68 216-34-8884 MD Director 11 38 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X☐Yes 2☐No items 23a or 28a-f shiner must be notified NA Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 U.S.A. 134 South Loudon Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Black þ 3 ☐ Widowed 4 ☐ Divorced "naturai". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housewife Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Henson John Henry Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 21229 Willis Jones-Husband 134 South Loudon Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/6/07 Randallstown, Md 21. Signature of Funeral Service Licenses Ma Your and forms of Ecitive 4300 Wabash Ave, Baltimore, Md 21215 23a. P/ n1. Enter the disease, or complications that can ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one can so on each line. Immediate Cause (Final **Physician** \supseteq hourd ease or condition sulting in death) /Medical Examiner Social familiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner¹ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 1 Impatient 2 ☐ ER/Outpatient 3□ DOA P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

strar's Signature

			1 - For State Registrar	State of I	Maryland / De _l	partment of He <i>rtificate of L</i>		nd Mental	Hygien	/ /	0001	+7
	Dhusisi		1. Decedent's Name (First, Middle, I	Last)				2, Date of		ay Yeer	3. Time of D	Death
	Physici /Medio		Alice L.	Jones				01	02	2007	12:45	A M
	Examir	er	4a. Facility Name (If not institution, g		er)	4b. City, Town, or	Location of	Death	40	c. County of Dea		
			Cherry Lane Nurs 5. Social Security Number 6		Ann (In use In at high do	Laurel	If Under 2	4 Hrs. 0 Com-	4.00-45	Prince (
	Funeral Director		578-34-0934	1□M 2√□F	Age (In yrs. last birthda 80 Yrs.	Months Days	Hours	Min. (Month	n, Day, Year) C	thplace (State or ountry)	
			Usual Residence of Decedent					101-31	<u>-1926</u>	was	shington D	
	d within 72 hours after death with the Maryland Jene. r than "natural", or Hems 23a or 28a-f show The Medical Examiner must be notified at	tor	MD 10a. State 10b. County Prince	Georges	10c. City, Town or Laure						10d. Inside City	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	ountry?	
	th wit		15 N. Bruce Street			20724			ι	JSA		
	e e e e e e e e e e e e e e e e e e e	Funeral	11. Marital Status	12. Was Decede Armed Force		Was Decedent of Hi If Yes, specify Cuba	spanic Origi	in? (Specify Yes of Puerto Rican, etc.	r No-	14. Race - Am Black, Whi		
36	or It		1 X Never Married 2 Married	1 Tyes 2 [X No	1 ☐ Yes 2 ☑ No	Specify:	Table Hour, Sto.	<i>'</i>	Specify: Bla		
Ö	hours tural'	d by	3 Widowed 4 Divorced	Year or Date		^						
15	within 72 ene. than "nat	Completed	15. Decedent's (Specify only highest of	rade completed)	(Gin	edent's Usual Occupa re kind of work done of DO NOT use retired.	furina most d	of working	16b. F	Kind of Business	/Industry	
77	filed within I Hygiene. other than	E O	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Housekeeper	,			Co11e	ane	
ğ	tile othe	Bec	17. Father's Name (First, Middle, La	st)	, , , , , , , , , , , , , , , , , , , ,	Housekeeper	18. Mother	's Name (First, Mic	ddle, Maidei		<u> </u>	
Maryland 21215-0036	2 should be and Mental Is marked o	To E	John J Jones					Millie E	mry			
any	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ling Address (Street a	and Number	or Rural Route No	ımber, City	or Town, State,	Zip Code)	
Σ,	and and m 27		Ronald Jones - So	on		05 Willow Cre	eek Cou	rt, Pinnac	le, Nor	th Caroli	na 27043	
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from Sta	20b. Place of Dis cemetery, cr	oosition (Name of ematory or other place	θ)	Date	20c. L	ocation - City or	Town, State	
Ë	Pag tment tent: jury c		'4 □Donation 5 □Other (Spec	city)	Metro Cre			1/04/2007		onsville,	Maryland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra		21. Signature of Funeral Service Lic	ensee well		22. Name and Addres 7601 Sandy	s ol Facility Spring	Fleck Fun Road, Laur	eral Ho el, MD	ome Inc., 20707		
	Priysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. £ A	sed the death. Do not en line.	nter the mode of dying	g, such as ca	ardiac or respirato	ry arrest,		Approximate Interval Betwee Onset and De	
п	Examiner		Sequentially list conditions	LOI	3NU1) a	Tent !	dise	ue			XIS.	
5.	D ==	iner	Sequentially list conditions, if any, leading to initiodate cause. Enter Underlying Cause (Disease or injury	Due to (or r	as a consequence of):	0	- 3	4 4 6				
10	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to for	as a consequence of):							
8760,	be exicient			200 (0) (0)	as a consequence on.							
687	tificate ng phys as the	edicai		d								And the same of
.O. Box	death cer e attendir od for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			_	23d. Date of de Month	livery Day Ye	ar
Records, P	ngi De	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause give	n in Part I.				the cause of dea	
900	e law requi has been s je 2 should	Completed	_						Vas an	24b. Were at	itopsy findings av	railable
Ě	The ate h page	E						a p 1□ Ye	utopsy erformed? es 2 2 No	death?	completion of cau 2□ No	ise or
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place o	of Death (Check or				
of <	99 10 15	P	1 ☐ Yes 2 Two	Hospital: 1 ☐ Inpa			G 4 Nurs	ing Home 5 🗆 F	Residence	6 ☐Other (Spe	cify)	
ū	ding P	on:	27. Manyler of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, E	njury 28b. Time Day Year) Injury	of 28c. Injury Work	at ?	28d. Descri	be how inju	ry occurred		
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigati 3 Suicide 6 Could not	he			'es 2 □ No					
Division	or Attendate death Director:	Certification;	4 Homicide determine	d 286. Place of I	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location City or	n (Street ar Town, State	nd Number or Ri 9)	ural Route Numbe	∌ľ,
_	pours cours (29a. Certifier 1 Certifying F	hysicien. To the her	st of my knowledge, dea	th coourned at the time	o data and i	place and due to	the seven(s)	\ and = anner ar	atata d	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Extended)	miner: On the basis and manner	of examination and/or i	nvestigation, in my op	inion, death	occurred at the tir	ne, date and	d place, and due	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	0		te signed (Mont		
			Nito	MS		1341	97	8		-2-	2007	7
	H		30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print) July	ilul	le Rd	A3	12 Bu	2007 ouse M.	071
	Sta Registra	1.00	31. Date liled (Month, Day, Year) JAN 0 4 2007	32. Regis	strar's Signature	K						,,,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Day Physician Shirley A. Jackson 1,2007 4c. County of Death 1:00pm January /Medical 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore Dundalk 7591 Ives Lane Apt. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Deys Months 1 ☐ M 2 ☐ XF Yrs. Director 216-40-1784 7-28-1945 Alabama Usual Residence of Decedent filed within 72 hours eftar death with the Maryland Hygiena. 10d. Inside City Limits 10a Stete 10b. Counts 10c. City, Town or Location rai', or items 23a or 28a-f shor Exeminer must be notified at 1 ☐ Yes 2 ☐ No Baltimore Dundalk Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 21222 USA 7591 Ives Lane Apt. B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Toll Collector 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Minnie J. Crawford Stanley Pietrowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 7591 Ives Lane, Apt. B Baltimore, Md. 21222 Daniel L HIcks, Jr- son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 St Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/5/07 Baltimore, MD Holly Hills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Fecility Joseph N. Zannino Jr. FH annung 263 S. Conkling St. Baltimore, MD 21224 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examine requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) ٩ 1 ☐ Yes this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Certification: Natural 5 Pending 1 🗌 Yes 2 □ No 2□ Accident investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Continuous of the death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only

Division Hospital or To the Hospital within 24 hours of To the Funeral I completely filled edicai

7-28-1945

O

29b. Signature and life of certifier

29d. Date signed (Month, Day, Year) 1-3-2007

31. Date filed (Month, Day, Year)

327 Registrer's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 0837 200 DAVI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSPITAL 5. Social Security Number TIMORE

If Under 24 Hrs. | 8 9. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** 219-05-1961 Usual Residence of Decedent Months Days Hours Min 1 M 2 □ F Yrs. Director death with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or Items 23a or Examiner must be r Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If'Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced ac Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Mediral 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Print) (daughter WOO กกก 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Brooks U.N. 1 M Burial 2 ☐ Cremation 3 ☐Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name an Address Joseph L 21. Signature of Funeral Service Licensee of Facility runeral 23a. Part. Enter the disease, or complications that complex, or heart fallure. List only one cause of elimediate Cause (Final disease or condition resulting in death) aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical s a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Est Examine as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division or Vital Records, 2 □ No 3 Probably 4 BUnknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 2K No 1□ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2200 ို ≥ DER/Outpatient 3 DOA 1 | Inpatient After this 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation (Month, Day Year) Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. Medical (Check on Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3 31. Date filed (Month, Day, Year) egistrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

2007

		State of Maryland / Dep		h and M	ental Hyg	•	00050
Physicia		Decedent's Name (First, Middle, Last) Barbara Ann Johnson	·		2. Date of Deat January	h	3. Time of Death 2:00P M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 923 W. 33rd Street	4b. City, Town, or Locati			4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 61 Yrs. last birthday 61 Yrs.	// If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Sept. 1	9. Birth Cour 8, 1945 Mar	place (State or Foreign intry) yland
ryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I					10d. Inside City Limits
r 28a-f s	Director	Maryland N/A Baltin	10f. Zip Code		1	0g. Citizen of What Cou	MXYes 2 □ No ntry?
eath with	erai D	923 W. 33rd Street 11. Marital Status 12. Was Decedent Ever in U.S. 13		1211	poits Voc or No.	USA 14. Race - Ameri	can Indian
should be filed within 72 hours after death with the Maryland nod Mental Hygiene. In a hygiene. In a hygiene of the than "natural" or items 23a or 28a-f show umatic evant, the Modical Examinar mant be notified.	i by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 No Specify		Rican, etc.)	Black, White,	etc.
hin 72 h en "natu Mudical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during i DO NOT use retired)	most of worki	ng	16b. Kind of Business/in	dustry
filed wil Hygien other th	a		emaker 18. M	other's Name	(First, Middle, I	Own Home	
Mal y fall of L. L. L. L. L. L. L. L. L. L. L. L. L.	To B	Charles Taylor			CSorley		
y Widel			lling Address (Street and Nu Cimarron Cir				
Dartill Togs 1 and 2 should be permit. Pages 1 and 2 should be permanent of Health and Menta Important: If item 27 is marked any injury or other traumetic ence.		1 Burial 2 Cremation 3 Hemoval from State	position (Name of sematory or other place)	1/5/2		20c. Location - City or To atonsville	
permit. P Departm Importar any inju		21. Signature of Funeral Service Licensee	22. Name and Address of F	acility	I crooms	Heros Tra	terit en en en en en en en en en en en en en
		23a. Part 1. # rier the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	631 Falls Roc	nd Bal	timore,	Maryland	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ———————————————————————————————————	Coronary A	litery	Thee	عدو	Onset and Death
Examiner	-	Source theils that one things					
ate be executed hysician and he burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):					
ate be expression he burial	icai	d.					
Beath certificate to attending physical for use as the E	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	ery
that the death	Physician/Med	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
w requires that been signed to should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in P	Part I.		pacco use contribute to t es 2 \(\hat{\text{\tiny{\text{\tint{\text{\tin}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex	
The taw cate has by page 2 sh	Completed				24a. Was a autops perform	y prior to co ned? death?	opsy findings available impletion of cause of
ysiclan: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☒No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpate	04	Action to the second second	n (Check only on me 5 Reside	e) ence 6 □Other (Specia	fy)
Attending Physiclen: The are death. sector: After this certificate he by the funeral director, page	Certification: 7	27. Manner of Death ↑★Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at			ow injury occurred	
al or Att	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	2	28f. Location (St City or Town	reet and Number or Rura n, State)	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. within 24 hours after death. Che Houser all Director: After this certificate has been signed by the attending phy contelety filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de. 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, dat investigation, in my opinion,	te and place, a , death occurre	and due to the ca	ause(s) and manner as s ate and place, and due t	tated. o the cause(s)
To t	Σ	29b. Signature and title of centifier	29c. License numb		2	9d. Date signed (Month,	Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a) (Typi Betsy Fan 3730 Falls Road F	0332	ND -	12.1.1	11-1-1	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Daltimore, 1	2	.1211		
Registr	ar	JAN 0 3 2007					

State of Maryland / Department of Health and Mental Hygiene For Stata Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:04 PM Elsie Κ. Kovacs January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A Augsburg Lutheran Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 07 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F Sept. PA 81 Yrs. Director 196-16-3658 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28e-f show 1 ☐ Yes 2 ☑ No Directo Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 754 Bridge Drive 21122 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary State Government 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any jury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be Katherine Unknown Adam Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward Kovacs, Jr. 754 Bridge Drive, Pasadena, (son) MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 04 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 2007 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) urosepsis Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown pheral vascular Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hypothyroldism page 2 s certificate Arthriti 2 310 Rheumafold 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 140 this After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire t 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 100058676 Balrtt, MIP Januar 2007 aun I. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Babitt MID. 25 Main Street suite 200 Reisterstown MD 21136 32 Rigistrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 0 5 2007

				State of Marylar	nd / Depa	rtment of H	lealth and M	-	1 3 1	07	00052
				- State Registrar	Cer	tificate of	Death		Reg. No.		
	н	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of De. Month	ath Day	Year	3. Time of Death
		/Medic Examin	al	Bessie Elizabeth Keithley 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	01	04 4c. Cour	2007 ty of Death	7:15 AM [™]
				Genesis Eldercare Franklin Woo		Baltimo	re, Maryl	and		timore	
		Funeral		1DM 2DE	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthpla Countr	ice (State or Foreign
		Director		220-09-4310 1 M 2X 94 Usual Residence of Decedent				12/29/1	912	Mary	yland
		/land			ity, Town or Lo	cation				100	d. Inside City Limits
-	• :	Man Hed	tor	MD Baltimore W	Mhite Ma	arsh					1 ☐ Yes 2 🔯 No
W		affer death with the Marylan or Itame 23a or 28a-f ahow)lre	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Countr	y?
1		23a	ral	5706 Keithley Road		21162			U.S.		- Ladia
7		after death w	une	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Was Decedent of H I Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No Rican, etc.)	- 14. H	ace - America ack, White, et	
EITHH	36	rs aft	by Funeral Director	1 ☐ Yes 2 ∭XNo 1 ☐ Yes, Give 3 ☐ XWidowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	1	I□Yes 2XNo	Specify:		Spec	whit	te
M	215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itame 23a or 28a-f ahow ta Medical Evandrar must be notitied at	ted	15. Decedent's Education	16a. Decec	ient's Usual Occup	pation	ina	16b. Kind of	Business/Indu	
F	215	e.	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. [OO NOT use retired	during most of work d)	ii ig			
	CA	T TO 1	To Be Completed	7	Ass	sembler	40 Mark and Mark	- /Fi Adid-dia		ee Food	ds
1	bu	be fill stal H d ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			ате)	
M	Maryland	2 should be to and Mental It is marked or raumatic ava	10	John B. Fortman 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	o Address (Street	Carrie			n State Zin (Code)
2	Ma	s 1 and 2 should be filed f Health and Mental Hyg ftam 27 Ia marked othe other traumatic avant,		_ X _ X _ X _ X _ X _ X _ X _ X _ X _ X			Lane - C				
5	ē,	s 1 and 2 if Health a itam 27 lu other trai		Mary E. Lawn 20a. Method of Disposition 20b.	Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	1 - City or Tow	m, State
111	e l	Page ento nt: If ry or		1 TABriugi 5 Clemation 3 Hemovaritoni State		Cemeterv		3/2007	Aberdee	n. Mar	vland
3	altimore,	permit. Pages 1 Depertment of H Important: If its any injury or oti once.		21. Signature of Funeral Service Licensee	22	. Name and Addre	ess of Facility E	F. Lass	ahn Fu	neral H	Home, P.A.
1	Ω .	88 = 8		E. F. Hassalw	11	750 Bela	ir Road -	Kingsv	rille, I	Marylar	nd 21087
				23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	, F	Physician		tmmediate Cause (Final disease or condition	S						Onsor and Boarn
•		/Medical Examiner		resulting in death) Due to (or as a conse-	quence of):	1.7					
		_xammoi	70	Sequentially list conditions, if any leading to immediate b. Due to (or as a conse	AUDICE OF	1142					
	134	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	C						
	<u>,</u>	e be executed sician and burial-transit	Exal	resulting in death) Last C. Due to (or as a conse	quence of):						
		ysicia ysicia	ez.								
	P.O. Box 68	Attanding Physicien: The law requires that the death certificate it creath. ector: Attenthis certificate has been signed by the ettending physis by the funeral director, page 2 should be detached for use as the the truncal director.	Physician/Medic	IF FEMALE:							
	Š.	ath ce Itendi	an/I	23b. Was decedent pregnant 1 Live birth 2 Fet	tal death 3	Ectopic pregnanc	у			Date of deliver	y Day Year
	0.	the el	sici	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	death 5 □	Other (specify)					,
	٩.	that the de ned by the e detached t	Ph	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco use co	ntribute to the	cause of death?
	ds,	w requires to been signer should be contact.	Completed by	End Shape Dem	idna	A		10	Yes 2□No	3 🗌 Proba	biy 4 nknown
	OS	w req s beer shou	lete	Coronary Artery	Vis	exore		24a. Was	an 241	. Were autop	sy findings available pletion of cause of
	Re	The lay ete has pege 2	mo	3.3.10.3				autor perfo	osy ormed? 2.00No	death?	
	ita	ilcien: Th certificete rector, peg	BeC	25. Was case referred to medical			26. Place of Deat				
	> =	hysicien: this certifice al director, p	10 1	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐			4 Williamsing ric	me 5 Resi			
	פים	tanding Phileath.		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occ	urred	
	sio	ottandli death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At 1	home form etc		Yes 2 No	28f. Location (Street and Nu	mber or Rural	Route Number
	Division of Vital Records,	Of A Direction by	Certification:	4 Homicide determined building, etc. (Spec	sify)	eet, factory, ornoe		City or To			
	_	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one)	nowledge, death	occurred at the tweetigation, in my contraction	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as sta e, and due to t	ited. the cause(s)
		o tha ithin 2 o tha omple	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig	ned (Month, D	Pay, Year)
		H 3 H 0) Pill MA		2	53462		1.	1/02	
	,	Γ		30. Name and address of person who completed cause of death (Ite	эт 23а) (Турө,	Print)			-,1	· 10 T	
	2)		Jude Munera mo	1845	OAKW	od Ropa	& Gle	W BO	mie,	WD SIDEI
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature						
	*	Registr	elf	JAN 0 5 2007	A 15 15 15 15 15 15 15 15 15 15 15 15 15						

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Please Type amend 1 Sta 1_ State	or Print tem 1 p te of Mar	in Blac er doc yland / l		lelible Ink. 53 1–5–07 rtment of H <i>tificate of I</i>		II Copies Mental Hy	Are I	Legible.	
Physicia /Medic	al	Henry	enry K	. Kac	inie	el —		2. Date of De Month Janua:	Day	Year 2, 2007	7:30 AM M
Examin Funeral Director	er	4a. Facility Name (If not institution give street a Patricia Smith's TLC 5. Social Security Number 218-42-9589 6. Sex	7. Age ('In yrs. last bii 74	rthday) _ Yrs.		Edgewood If Under 24 Hrs. Hours Min.	8. Date of Bir	Ha	Co	nplace (State or Foreign untry)
Maryland -f show iled at	tor	Usual Residence of Decedent 10a. State 10b. County MD Harford	1	0c. City, Tow		eation					10d. Inside City Limits 1 ☐ Yes No
ath with the 33a or 28a rust be noti	Funeral Director	10e. Street and Number 3433 Tree Frog Court				10f. Zip Code 21009			USA		
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dikal Examiner must be notified at	þ	1 Never Married 2 Married	s Decedent Evened Forces? Yes No es, Give ar or Dates:	er i n U.S.		Vas Decedent of H FYes, specify Cuba □ Yes 2 No	lispanic Origin? (Span, Mexican, Puerti Specify:	pecity Yes or No o Rican, etc.)		14. Race - Amer Black, White Specify: Whi	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 12	leted) lege (1-4or 5+)		(Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired and Die	during most of wor	king	16b. Ki	nd of Business/I	
tould be filed Mental Hyg narked other	To Be C	17. Father's Name (First, Middle, Last) Jan Kaciniel	-0	101		Address (Chron	18. Mother's Nam Amelia and Number or Ru	Unknown			7- O- d-)
s 1 and 2 sh of Health and item 27 Is π other traum		19a. Informant's Name/Relationship (Type. Pri. Danuta Wilson/Daughter 20a. Method of Disposition		3	3433		og Court		n, M		
Department (Depar		1 ☐ Burlal 2 ♣ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	rrom State		apeal 22. C	ke Cremat Name and Addre	tory Inc.	2007	nativ	es	Maryland
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the on each line.	avoni	not ente		ng, such as cardiac		ırrest,	more, Ma	Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a d	DM!	lypa	7 m	N.				3yrs 10yrs
Physician: The law requires that the death certificate b this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the b	Physician/Medical	in the past 12 months?	es, outcome pf]Live birth 2]Pregnant at tir]Unknown	Fetal deatl		Ectopicpregnancy	у			23d. Date of deli Month	very Day Year
le law requires that the de has been signed by the a ge 2 should be detached	þ	Part II. Other significant conditions contributing	g to death but	not resulting i	in the un	derlying cause giv	en in Part I.	23e. Did	/		the cause of death?
n: The law r ficate has be or, page 2 sh	Completed	25. Was case referred to medical					00 Plant of Page	1□ Yes	psy ormed? 20 No	prior to death?	topsy findings available completion of cause of
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ion: To Be	examiner? 1 Yes 2 No Hospita 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient Date of Injury (Month, Day)	28b.	utpatient Time of Injury	Wor	4 ☐ Nursing H	ome 5 Res	idence (6 Other (Spec	city) Resilyone
tal or Attences after death al Director: ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e	Place of injury building, etc.	/ - At home, fa (Specify)	arm, stre	eet, factory, office	res 2 lino	28f. Location (City or To	Street an wn, State	d Number or Ru)	ral Route Number,
the Hospi in 24 hour the Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: 0 ar		xamination a		estigation, in my o	opinion, death occu		, date and	d place, and due	to the cause(s)
vith vith corr	Σ	29b. Signature and title of certifier	pidde	us.		29c. Licens	25 83		29d. Dat	le signed (Monti	n, Day, Year)
5		30. Name and address of person who complete Step No. D. Smalld J. V. 31. Date filed (Month, Day, Year)	d cause of dea	7 Old	Ejy.	notes Ad	Ste 21	f-220	BU	Ais à	21018
Sta Registr		JAN 0 5 2007	A COREA	w B	1	nack)					

			for State Registrar	State	of Maryland		artment of H			200	7 000	154
	7	-	Decedent's Name (First, Midd	fle, Last)			timouto or i	Journ	2. Date of Deat	eg. No. h	3. Time	of Death
П	Physici		Sarah Marie						Month	Day	Year	
17	/Medio Examir		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of Deat	<u>January</u>	1, 2007		30 A ^M
Н	LAGITII		921 Morris Ave	-			Luthery			Balti	more	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs			9. Birtholace (State	e or Foreign
	Director		220-30-5640	1□M 2-F	97	Yrs.	Months Days	Hours Min.	Feb 28,	1909	Maryland	į
	D .		Usual Residence of Decedent		10- 01-	T						
	aryla •hov	<u>-</u>	MD Balt			Town or Lo						City Limits es 2X No
	Ne M	Director		LINGIC			.,					33 ZA 140
	3a or	i D	10e. Street and Number 921 Morris Ave	enue			10f. Zip Code 21093			0g. Citizen of W	hat Country?	
	ma 2	Funerai	11. Marital Status		cedent Ever in U.S		Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-		- American Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exameter must be collined at once.	by Fur	1 ☐ Never Married 2 ☐ Ma 32☐3Widowed 4 ☐ Divorce	If Yes G	2 XX No aive		f Yes, specify Cuba 1 ☐ Yes 2 🛣No	n, Mexican, Puer Specify:	to Rican, etc.)		k, White, etc. White	
Ö	2 ho	Completed by		nt's Education		16a. Dece	dent's Usual Occupa	ition		16b. Kind of Bus	siness/Industry	
215	thin 7	pie	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work done of DO NOT use retired,	uring most of wo	rking			
Ŋ	od wi	S	llth grade			Ins	pector			Blood 1	Lab	
	be fill tal Hy d oth	Be	17. Father's Name (First, Middle	, Last)					me (First, Middle, A	Maiden Sumame	e)	
Z	ould Men varke	²	Joseph Rosso					Mary Dis			,	
Maryland	12 st h and 7 le n traun		19a. Informant's Name/Relation				ng Address <i>(Street a</i> orris Ave					13
	1 and Healt em 2		Andrew King, 8	son			sition (Name of	nue, nu			City or Town, State	
ē	ages int of t: If it		1 Burial 2 Cremation		n State cen	netery, crer	natory or other place	· L	5, 2007			
Baltimore,	artme ortan ortan injury		4 □Donation 5 □Other (3		Most	-	Redeemer					anu
ñ	Department Department		HOR				15 Belair					
	-		23a. Part1. Enter the disease of shock, or heart failure. Lis	complications that only one cause on	caused the death.	Do not ent	er the mode of dying	, such as cardia	c or respiratory arre	est,	Approxim Interval B	ate Setween
ų,	Pnysician		Immediate Cause (Final disease or condition		DYG	DIW	MM				Onset an	Death
Mi.	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ince (f):	10	1			100	4)
	Examiner		Sequentially list conditions, if any, leading to immediate	b. —	I.	Δ .	$\triangle \triangle$	1			104	diri
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseque	n a eth	7	,				
_	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to	(or as a consigue	uncer ()	W (eM)	HOY \			109	eon-
8/60	cate be executed physician and the burial-transit				(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	II						
287	ficate physis the	edicai		d		-11						
XOA	eath certifi attending for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pregnance	су				23d Date	of delivery	
	0 00 0	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Preg	birth 2 ☐ Fetal d nant at time of dea		Ectopic pregnancy Other (specify)			Mont	,	Year
J.	that the dended by the a	Physiclan/Me	9 □ Unknown	9□ Unkr	nown							
	es tha igned be det	ру Р	Part II. Other significant conditi	ons contributing to	death but not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use contri	bute to the cause o	f death?
Vital Records,	The law requires that the to be seen signed by the base been signed by the sage 2 should be detached.								1 🗌 Ye	s 2□No 3	3 Probably	Unknown
ပ္ပ	law re as be 2 sho	Completed							24a. Was an	24b. W	ere autopsy finding for to completion of	s available
ř	The ate ha	E O							autopsy perform 1 ☐ Yes 2	ied? de	eath?	cause or
<u> </u>	sician: The law certilicate has { irector, page 2 s	Be (25. Was case referred to medica examiner?	M .				26. Place of Dea	ath (Check only one			
0	Physic this o	ဥ	1 ☐ Yes 20 No			R/Outpatien	t 3□ DOA Othe	r: 4 🗌 Nursing H	lome 5 Resider	nce 6 Other	r (Specify)	
	ding P h. After funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	19	of Injury orth, Day Year)	8b. Time of Injury	28c. Injury Work	?	28d. Describe hor	w injury occurre	d	
<u>s</u>	death.	icat	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	not be				'es 2 □No				
DIVISION	after deat Director:	Certification:	4 Homicide determine	nined 200. Flac	e of Injury - At hom ling, etc. (Specify)	ie, rarm, stri	eet, ractory, office		City or Town,	eet and Number State)	r or Rural Route Nu	ım <i>bər</i> ,
	spita nours neral		29a. Certifier 1 Certifyi	ng Physician: To th	e best of my knowl	edge, death	occurred at the time	e, date and place	, and due to the ca	use(s) and man	ner as stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the t	pass of examination oner stated.	mand/of inv	estigation, in my op	inion, death occu	trred at the time, da	te and place, ar	nd due to the cause	(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certific	er 🗡			20c License	number	/ 29		(Month, Dey, Year)	
	$\langle \cdot $		P /		14		104	L756	5	1-2	-07	
	Ü		30. Name and address of person	111	A	1		-	son, M	` .	4.	
	100 to 100		4 ymac Al 31. Date filed (Month, Day, Year,		7600 Os Registrar's Signatur		Dr. #411	10W	son, 111	D YIZC	94	
	Sta Registra		JAN 0 5		M.	Son	ask B					
			ט ט וות ט	_ L_UUI STATE	TOTAL STREET	1400 VID 1500	- 10 all al					

			1 - For State Registrar	State of Maryland		irtment of H tificate of L		Aental Hygie Reg	2001	00055
	Physici	an	Decedent's Name (First, Middle, Last) Dolores A	gnes Kane				2. Date of Death Month	Day Yee	
	/Medic		4a. Facility Neme (If not institution, give s			4b. City, Town, or	Location of Death		01 2007 4c. County of De	12:15 P ^M
1			1033 Riverside A			Baltimor			n/a	
	Funeral Director		5. Social Security Number 6. Sex 1 214-20-9361	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You Feb. 04.		irthplace (State or Foreign Country) W York
pue	3.2		Usuel Residence of Decedent 10a. State 10b. County		Town or Lo	cation		100.07,	1/2/	10d. Inside City Limits
Maryle	faho	tor	Maryland N/A		ltimo					1 1 Yes 2 □ No
ith the	or 28a	Director	10e. Street and Number		I CIMO	10f. Zip Code		10g.	Citizen of What	,
death with the Maryland	nust t	Funerail	1033 Riverside Av	enue 12. Was Decedent Ever in U.S.	12 V		230	pacify Vac or No	U.S.A	nerican Indian.
USO urs after d	al', or itam Examinar	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		Vas Decedent of Hi FYes, specify Cubar □ Yes 2 1 No	Specify:	Rican, etc.)	Black, W	
IZIS-003	Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or liteme 23a or 28a-f ahow any njury or other traumatic event, the Medical Examinational be notified at another.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Deced (Give life. D	lent's Usual Occupa kind of work done d DO NOT use retired,		king 161	b. Kind of Busines	ss/Industry
D Pelli	other i	Be Co	9 17. Father's Name (First, Middle, Last)	0		Housewif		e (First, Middle, Mai	Home iden Sumame)	
ylar ould be	Menta arkad atic e	ToB	Charles S. Wri				Dolor		Murphy	
Mar d 2 sh	Ith and 27 is m traum		19a. Informant's Name/Relationship (Ty) Charles E. Kane	(husband)				ra <i>l R</i> oute <i>Number, C</i> Raltimo:		, Zip Code) land 21230
s 1 a	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Plac	e of Dispos	sition (Name of natory or other place	1	The state of the s	c. Location - City	
altimo	tant: H		4 □ Donation 5 □ Other (Specify)	Mary		Veterans	1			le, Maryland
De d	any r		21. Signature of Fugeral Service License	Derull						land 21230
	ysician		23 art1. Enter the disease, or compositions, or heart failure. List only in mediate Cause (Final disease or condition	e cause on each line.						Approximate Interval Between Onset and Death
	ledical aminer		resulting in death)	Due to (or as a consequent	nce of):	Vascul.	r Disea	A - 0		5 years
p _e	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sonsequer	new cit):	40.70				
oU, e executed	physician and s the burial-transit	i Examln	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					
OO / OU, ficate be ex	physic s the b	edicai	d							
death cert	been signed by the attanding should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
thatth	ed by		Part II. Other significant conditions con	tributing to death but not resulti	ng in the un	iderlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?
w requires	en sigr buld be	ed by	Lung Conce	r				1 ☐ Yes	2 □ No 3 □	Probably 4 Thinknown
The law requires that the	ate has be page 2 sh	Completed	Chronic obs	tructure fol	~~~	<u>~7 912</u>	Core	24a. Was an autopsy performed 1 Yes 2	d? prior to	autopsy findings available completion of cause of
V 11.d Sician:	certific irector,	o Be	25. Was case referred to medical examiner?	ospital:		Othe		h (Check only one)		
2 4	ter this neral di	\vdash	27. Manner of Death	1 Inpatient 2 EF	VOutpatient Bb. Time of Injury	28c. Injury Work	4 Nursing no	ome 5 Residence 28d. Describe how		necify)
Attending	tor: Af	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 Y	es 2 □No			
Ital or Al	within 24 nous state loads. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town, S	State)	Rural Route Number,
Hosp	Fune etely fi	edical	29a. Certifier 1 Certifying Physical Examinations (Check unity 2) Medical Examinations (Check unity 2)	ician: To the best of my knowle ier: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
To the	To the	Me	29b. Signature and title of certifier			29c. License		29d.	Date signed (Mod	nth, Day, Year)
			1	Mo			8675	Ja	1 2	2007
į	2		30. Name and address of person who co				ITE 60	5 BALTI	mone a	10 21202
	Sta Registr		31. Date filed (Month, PANY 4 2	007 32. Registrar's Signatur	5. Asj			5 BALTI		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:30 а м Mary V. Kromm 2007 January 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Augsburg Lutheran Home <u>Baltimore</u> Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs 98 Director 218-36-8430 May 30, 1908 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified any Injury or other traumatic event, the Medical Examiner must be notified. Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21207 6811 Campfield Road United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addison F. Smoot Mary V. Disney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 19a. Informant's Name/Relationship (Type. Print) Robert K. Headley / Nephew 6510 41st Avenue, University Park, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Qation 5 NOther (Specify) Entombment Loudon Park Cemetery 1/6/07 Baltimore, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dement /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) signed by the attending physician to detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760 Division or Vital Hospital or Attending Physician: 24 hours after death. within 24 hours a completely

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and manner stated.

M, D

32 Registrar's Signature

aren I. Balatt, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Babitt

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DODS8676

25 Main sweet, suite 200, Reistelstown MD 21136

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien@ [] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 Hoom Year **Physician** 072:300 HOTEKCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard home Culimbio NUrsa Lorien If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Aug 27, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XF 95 Yrs. 214-03-0791 Director Canada Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be nutified at 1 ☐ Yes 2 XNo Funeral Director Maryland Baltimore Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Placid Woods Court 21234 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiane. Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed v nent of Health and Mental Hygia ant: If Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arnold Feader Florence M. Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip J. Korb, Nephew 15 Placid Woods Court Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Dapartment of importent: If any injury or once. injury or 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 01/03/07 Baltimore, Maryland 21. Signature of Funeral Service (rigensee Cremation Society Of Maryland Inc. 299 Frederick Road baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** my cadial disease or condition resulting in death) marctus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last b Examiner Due to for as a consequence off The law requires that the death certificata be executed ed by the attending physician and datached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed page 2 should be dat Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performe 1 🗌 Yes 2 X No the Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 11/ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier mpletely one) Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of pertifier 29d. Date signed (Month, Day, Year) 29c. License number 1107 00053709 layou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pialler) UX lann HITWLA 14 00 STE # Li. 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State MD 207/1 JAN 0 4 2007 Registrar

07-00016 Romaine Kennedy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			ficate of	Death		75	g. No. 200	7 0005
Physicia Nedical Exami		Decedent's Name (First, Middle, Last) ROMAINE	KENNEDY					2. Date of Deat Month January 1,		3 Time of Death 1412 hrs
		4a. Facility Name (if not institution, give			4t	o. City, Town, or L Baltimore	ocation of Deat		4c. County of Deat	h
Funeral		Social Security Number 6. S	7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24Hr			thplace (State or
Director		219-40-6703 1	м 2ХХ г	6	5 Yrs.	Months Days	Hours Ma	12/05/	1941 Co	gn _{buntr} MARYLAND
any		Usual Residence of Decedent 10a State 10b. County		Oc. City, To	own or Locatio	n				10d Inside City Limits
/aryland 28a-f show any 1 at once.	ţ	MARYLAND N/A			BALTIMO					1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e Street and Number 423 OXFORD COURT				10f. Zip Code 21201		10	Og. Citizen of What Cou U.S.A.	ntry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shimatic event, the Medkeal Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent E Armed Forces?	ver in U.S.				pecify Yes or No-		ican Indian, Black,
fter deal I", or it				X No		es 2 X No		- 1 1 1 /		ACK
hours ai natural Examin	ed by	15. Decedent's Education (Specify onl			6a. Decedent's	s Usual Occupation	on (Give kind of		16b. Kind of Business	
0036 within 72 iene ier than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+		PRESSEI	3			DRYCLEAN	ERS
15-0 filed will Hygie ed other		17. Father's Name (First, Middle, Last)				18		e (First, Middle, M	,	
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygiene n 27 is marked other than numatic event, the Medica	To Be	OSCAR SEABREE 2 19a. Informant's Name/Relationship (Ty			19b. Mailing A	Address (Street		N HUGHES Rural Route Num	ber, City or Town, State	e, Zip Code)
- p = e =		Samuel R. Kennedy 20a Method of Disposition	Jr./Son	20b. Pla		iddenhol		cle, Hin	esville, G	
Baltimore, Definit Pages I at Department of Hee Important: If ite injury or other tr		1 XBurial 2 Cremation 3 Donation 5 Other Specific	Removal from State	e cre	matory or othe RISON I	r place)		-09-07	OWINGS MI	
Baltir permit I Departme Importa injury or	Ì	21. Signature of unitral Source sice is		GAR	22. Na	me and Address	of Facility		FUNERAL H	
Physician	-	23a. Part I. Enter the disease, or compli	Cations that caused th	ne death. D	1 120)6 W NOR'	TH AVEN	UE		Approximate Interval
/Medical Examiner		failure. List only one cause on each immediate Cause (Final disease a.	Metastatic		oma to tl	ne liver				Between Onset and Death
*		or condition resulting in death) Sequentially list conditions, b.	ue to (or as a conseq	uence of):						
	Examiner	if any, leading to immediate Emails Fritor Underlying Gauss	ue to (or as a conseq	uence of):						
ecuted and transit	Exan	(Disease or injury that initiated events resulting in death) Last	lue to (or as a conseq	uence of):			_			
) be execute ician and irial - trai	Medical	X UNPENDED	AMENDED #23a,	27.perl	ME. G864	. 2/2/07 T	 Т			
8760, hificate be en ang physiciar as the burial		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnar	ncy		Ectopic pregn	ancv	23d. Date of deliver	y Day Year
Box 68: e death certifi the attending ed for use as a	Physician	past 12 months? 1 Yes 2 No 9 ✓ Unknown	4 Pregnant at tit	me of death	, - =	r (Specify)			2	,
Ch the by	by Ph	Part II. Other significant conditions		out not resu	ulting in the un-	derlying cause giv	ven ≀n Part I.	23e Did tol	pacco use contribute to	the cause of death?
ds, P.C equires that een signed uld be deta								1 Yes	2 No 3 Pro	topsy findings available
COFC The law represents the has be	Completed							autops perform	prior to death?	completion of cause of
tal Rection: The l	Be Co	25 Was case referred to medical examiner?				-	of Death (Check		2 V No 1 Y	es 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been steed in by the funeral director; page 2 should the	٤	1 V Yes 2 No 27. Manner of Death	Inpatient 28a. Date of Injury		R/Outpatient 8b. Time of Inju				Residence 6 Othe	r: Scene
ion (trending beath.	Certification:	1 X Natural 5 Pending 2 Accident Investigatio	(Month, Day,Yea	r)		1 Ye	es 2 No			
Divis pital or A ours after of	iği Si	3 Suicide 6 Could not b	28e Place of Initial	ry - At home	e, farm, street,	factory, office bu	ilding, etc.	28f. Location (So or Town, St	treet and Number or Ruate)	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a Certifier 1 Certifying Physicia	n: To the best of my						e(s) and manner as stat	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: 29b Signature and title of certifier	On the basis of exami and manner stated	nation and/	or investigatio	n, in my opinion,		at the time, date a	and place, and due to the 29d. Date signed (Mo	
IDX		hij hi,	mo			O.C.M			January 3, 2007	, 50,,100()
and		30 Name and address of person who co	ompleted cause of dea	,	,	Baltimore, M	ID 21201			
		31. Date filed (Month, Day, Year)	32. Registrar's	Signature		200				
Regist	rar	IAN 0 4 200	1 prospectores	200	5					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Thomas R. Lewis III JANUARY 3, 2007 10:500 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Oct. 10, 1961 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Days Hours 1 XM 2 ☐ F 45 West Virginia 212-92-0789 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 TYes 2 TXNo Maryland Baltimore County Baltimore 10e, Street and Number 10g. Citizen of What Country? 10f Zin Code 8635 Hoerner Avenue 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed None 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas R. Lewis, Sr. Eleanor Greathouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Wanda Lewis (Wife) 8635 Hoerner Avenue, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr. P.A. 2325 York Road Timonium, Maryland 21093 Scarn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIABETIC KETACIDOSIS WITH SEVERE ACIDEMIA Due to (or as a consequence of) HYPERKALEMIA Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ACUTE RENAL <u>FAILURE</u> Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown HISTORY OF ALCOHOL ABUSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an 2 No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examine be executed

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be netified at

the

marked other

permit. Pages 1 and 2 should be in Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ever

Director

Funeral

ģ

Completed

Be

ည

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

/Medical

detached

attending physician

has

Physician/Medical law requires that the death certificate þ Completed Physician: Be Certification: To this Prospital or Attending Pl 24 hours after death. Funeral Director: After the filled in by within 24 hours a To the Funeral I Medical completely

State

Registrar

FRANKEL R. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a, Certifier

JAN 0 5 2007

0. 7601 3. Registrar's Signature

0

and manner stated.

H0058708

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 011ie Livesay 6:00p 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Nursing Center Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 😿 F 216-30-2953 91 Yrs. Director 23 Aug. 1915 VA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natura!", or items 23a or 28a-f show idical Examiner must be notified at Md Carroll Sykesville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 7312 First Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give A Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 □ Divorced Specify.white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) LPN health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Robinette Osborne Naomi Tomlinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Killett (daughter) 7312 First Ave., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wesley Freedom Cem. 4 □ Donation 5 □ Other (Specify) 1-6-07 Eldersburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herber P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Zuks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O, Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2☑No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of eause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has trector, page 2 s 1□ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2<u>₽</u> No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 atural (Month, Day 5 ☐ Pending investigation 1 Tes 2 No hours after death 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only within 24 h To the Fu one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Daje signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

Day,

JAN 05

URNES

2007

istrar's Signature

07-00088 Patsy Ann Linker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yland 7 Department of Health and Mental Hy Registrar Certificate of Death	o .	No. 200	7 0006
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) PATSY ANN LINKER	2. Date of Death Month January 3,		3 Time of Death 2055 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 178 West Main Street Westminster	ouridary 5,	4c. County of Death	
Funeral		5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		215-32-4742 1 M 2XF 70 Yrs Months Days Hours Min. Usual Residence of Decedent	04/26	/1936 Foreig	untry) MD
* any		10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show 1 at once.	ţo	MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code		0.11	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	178 WEST MAIN ST. 21157	100	g. Citizen of What Coun	u y ?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f she atte event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No		14. Race - Americ White, etc.	can Indian, Black,
s after d ral". or	by Fi	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:		- 10 - 0 - 0	ITE
72 hours n "natu al Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of word during most of working life. DO NOT use retired		16b. Kind of Business/Ir STATE	ndustry
15-0036 filed within 72 I Hygiene of other than the Medical	Completed	12 PURCHASING CLERK 17. Father's Name (First, Middle, Last) I 18 Mother's Name (GOVERNMEN	T
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be			aRue CRAF	BBS
MD 21 d 2 should th and Me n 27 is ma		19a Informant's Name/Relationship (Type, Print) DENNIS W. LINKER, SRSON 2201 PLEASANT RUN			
C 62 = 77				20c Location - City or	
트 를 잃 을 하		4 Donation 5 Other Specify: PLEASANT VALLEY CEM. 1			
Balt permit Depart Impor injury	9 79	1254 E MAIN ST	WESTM	TNSTER M	OME, P.A. ID 21157
Physician /Medical		23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Dediti
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
. b. p. iii	Examiner	Cusease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
be executed ician and arial - transit		d. UNPENDED AMENDED			
760 icate l	/Medical	IF FEMALE. 23c. If yes, outcome of pregnancy	_	23d Date of delivery	
Box 687 death certification attending	Physician	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnan 1 Yes 2 No 9 V Unknown 1 Unknown 2 Other (Specify)	су	Month D	ay Year
P.O. Boy that the death	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to ti	ne cause of death?
ords, P.O v requires that t s been signed by	ed by	Chronic alcoholism	1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
Cord law req has bee	Completed		24a Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
tal Rec rian: The l certificate l ector, page		25. Was case referred to medical 26. Place of Death (Check or	1 ✓ Yes 2		2 No
of Vital Records, by Physician: The law require then this certificate has been si neral director, page 2 should by	To Be			esidence 6 🗸 Other:	Scene
- = ^ = l	tion:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	88d Describe ho	w injury occurred	
Division pital or Attendio	Certification:	Suicide Codid Not be	8f. Location (Stroor Town, Sta	eet and Number or Rurate)	al Route Number, City
15 E E		4 Homicide (Specify) 29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and death occurred at the time.	ue to the cause(s) and manner as state	d.
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	the time, date an	id place, and due to the	cause(s)
		296 Signature and title of certifier Patter: On once Poller 100.C.M.E.		29d Date signed (Moni	m, ∪ay, rear)
ib	-	30 Name and address of person who completed cause of death (Item 23a)	MD 34304		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, IVID 21201		
Regist	rar	JAN 0 5 2007 Maria & Joseph			

	1- For Amend #19a, perInf, &8	of Maryland / Depa 53, 1/23/07 II Ce	artment of Health and rtificate of Death		ne N2007 00062
	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physician	Hsiu-Fang Lee			Jan. 1,	2007 Year 3:34 Am
/Medical Examiner	4a. Facility Name (If not institution, give street and	i number)	4b. City, Town, or Location of Dea		4c. County of Death
	Suburban Hospital		Bethesda		Montgomery
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
Director	577-92-4771 1□ M 2反	79 Yrs.	World Days 110013	Dec. 26,	1927 China
and and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
Mary feath	Maryland Montgomery	Rockville			1 ☐ Yes 2 ☑ No
6 after death with the Mar or Iteme 23a or 28a-1 at infract must be notified Funeral Director	10e. Street and Number	ROCKVITTE	10f. Zip Code	10a.	Citizen of What Country?
23a o	5706 Sugarbush Lane		20852	1	ited States
deat	11. Marital Status 12. Was	Decedent Ever in U.S. 13.1 d Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
or its	1 Never Married 2 Married 1 Yes	es 2⊠No	lf Yes, specify Cuban, Mexican, Puèi 1 □ Yes 2幫 No <i>Specify:</i>	to Hican, etc.)	Black, White, etc.
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Mudical Examinar must be rotified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced Year	or Dates:	TEL 165 ZEL NO Specily.		Specify: Asian
ind 21215-00 be filed within 72 hou tal Hygiene. d other than 'natura event, the Medical event, the Medical Be Completed	15. Decedent's Education (Specify only highest grade comple	ed) 16a. Deced	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b	. Kind of Business/Industry
within than	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+)	emaker	1	Own Home
filed Hygin	17. Father's Name (First, Middle, Last)	Home		me (First, Middle, Maid	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Environment of Health and Mental Hygiene. Environment of Health and Mental Hygiene. To Be Completed by Funeral Director	UNKNOWN Lee		UNKNOWN		on something
shou shou umat	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or R	ural Route Number, Ci	ty or Town, State, Zip Code)
Mand 2	Warren Lee Son		Sugarbush Lane,		
Baltimore, sermit. Pages 1 ar Deperment of Heal Deperment of Heal My Indian or other and other a	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place) Janu	Date 6, 200	Location - City or Town, State
Fagner Pagner Pa	1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	om State		לחת	thesda, Maryland
Salt srmit. spent sports by injure.	21. Signature of Funeral Service Licensee		Name and Address of Facility Une	the state of the s	
m gg = 5 a		M00896 300	O W. Montgomery Ave.,	Rockville, N	Maryland 20850-2805
	23a. Part1. Enter the disease, or complications the shock, or head failure. List only one cause				Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Arterio Scieno	tic Cardiovascun	hr Disea.	Onset and Death
/Medical Examiner	resulting in death)	to (or as a consequence of):		77 15 15 150	
	Sequentially list conditions b.				
nine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):			
D, executed on and ial-transit Examiner	resulting in death) Leet	to (or as a consequence of);			
6876(6876) GBT GBT GBT GBT GBT GBT GBT GBT GBT GBT	d.				
Box Box lath certification of the certification of		outcome of pregnancy			23d. Date of delivery
P.O. Box 6 that the death certific ed by the attending detached for use as Physician/Me	in the past 12 months?	egnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
by the arche	9 Unknown 9 U	nknown			
Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physician/Me.	Part II. Other significant conditions contributing t	o death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Cords cords wrequire been sig				1 ☐ Yes	2 No 3 Probably Unknown
Recor The law requ the hes been age 2 should				24a. Was an	24b. Were autopsy findings available
I Record The law requires the seen seen seen seen seen seen seen se				autopsy performed	prior to completion of cause of death?
f Vital Revision: The reconflicate he director, page	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☑ i	No 1 Yes 2 No
of Vital Of Vital Physician: This certificate al director,	examiner? 1 Tes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatient	0#	lome 5 Residence	6 ☐Other (Specify)
HS: After the tuneral tion:	27. Marrier of Death 1 Natural 5 ☐ Pending (A	ate of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in	
Vision Vision Attending r death. ector: Attention filication	2 Accident investigation		M 1 Yes 2 No		
Division of Vital Records, Division of Vital Records, its elected death. The law requires is elected death. The certificate has been signified in by the funeral director, page 2 should be Certification: To Be Completed by	determined 206. FI	ace of Injury - At home, farm, stre ilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
Hospital Hospital Funeral Et hours e Funeral Cellical Ce	29a. Certifier 1 Certifying Physician: To				
- 14 - 0 - 1	2 medical examinet: On th	the best of my knowledge, death e basis of examination and/or inv anner stated.	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cause arred at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
To the within 2 to the comple	29b. Signature and title of certifier	arrier stateg.	29c. License number	29d. [Date signed (Month, Day, Year)
T SHO	1 da la the	$m\Omega$	D34174		13/0 7
1	30. Name an address of person who completed c	ause of death (Item 23a) (Type 5		//	207
20	Robert Joseph Rothstein			, Bethesda	, Maryland 20814
State	31. Date filed (Month, Day, Year) 32	. Registrar's Signature			
Registrar	JAN 0 5 2007_	Algeria Is A	and I		

			For State Registrar		State of	f Marylar		artmen rtificate					Reg. No.	/	7	000	163
	Physicia	ın	Decedent's Name (First,	Middle, Lasi	1)		LABO	OVITZ				2. Date of De		2007		3. Time of D 9:45	
•	/Medic Examin		4a. Facility Name (If not institution, give street and number) MANOR CARE NURSING HOME						4b. City, Town, or Location of Death TOWSON				4c.	4c. County of Dea			
1.0	Funeral Director		5. Social Security Number 028-12-3677	6. Se	x □ M 2√ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi	7 1924	9. B	lirthplac Country	MAS	Foreign S.
	land ow		Usual Residence of Decedence 10a. State 10b. C			10c. Ci	ty, Town or Lo	ocation							10d	. Inside City	y Limits
	8a-f sh	ector		BALTIM	ORE		RANI	DALLS					10a Citi	zen of What (1 □ Yes 2 XNo		2 XN0
	3a or 2	i Dire	10e. Street and Number 9805 SOUTHA			10f. Zip	Code	2113	3		rog. Citi	USA					
920	s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mential Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 X Widowed 4 Dh	edent Ever in U prces? 2 X No ve vates:		Was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.					
Baltimore, Maryland 21215-0036	thin 72 ho e. en "natu Mudical	Completed by	15. De (Specify only Elementary/Secondary (ucation de completed) College (1	1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d	durina mos	st of work	ung		nd of Busines			.D.T.O.
121	iled wit Hygien ther th	Con	17. Father's Name (First, M				CLE	RK		18. Mothe	er's Nam	e (First, Middle		O. GAS	\$ &	FLECI	RIC
/lanc	2 should be filed within and Mental Hygiene. Is marked other then saumatic event, the Me	To Be	CHARLES				PAL			SAR	АН		NAI	DITCH			CKER
Man	od 2 sho lth and 27 is ma trauma		19a. informant's Name/Re									RANDAL					
ore,	jes 1 and 2 of Health if item 27 i		20a. Method of Disposition		Removal from		Place of Dispo cemetery, cre					Date		cation - City			
ltim	permit. Pages 1 Department of H Important: If ite eny injury or ot 2005.		4 □ Donation 5 □ O 21. Signature of Funeral S	ther (Specify	')	∣BA	777	E HEBI 2. Name ar)4/2007)L LEVI	_				
Ba	Depa Impo eny in		Rout	/	Zw			8900 I	REIS	TERST		ROAD -			, M	D 212	
•	Physician /Medical Examiner		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ase, or comp e. List only	a. A	each line.	sclou					or respiratory Scula		usose		opproximate nterval Betwonset and D	Death
Jeo. 1097	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	(or as a conse											
1 A 1.0. Box 687	The law requires that the death certificate tee as been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 □ Yes 2 D No 9 □ Unknown		1 ☐ Live b	itcome of pregr birth 2 □ Fet nant at time of own	al death 3	⊒Ectopic pi ⊒ Other (sp		Nin-water		===i		23d. Date of o Month			'ear
JS, P	ires that signed to be det	by	Part II, Other significant of	art II. Other significant conditions contributing to death but not resulting in the underlying							g			tobacco use contribute to the cause of death? Yes 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) \(\frac{1}{2} \subseteq \text{Unknown} \)			
Si	The taw requirate has been sipage 2 should	Completed	peri phe	no	Jasu	lai	dise	ase				24a. Wa aut per	opsy formed?	prior i	to com	sy findings a pletion of ca	available ause of
Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to a examiner?	nedical	Lie anite li				0#		e of Dea	th Check only	/ \				
T) \O	ling Phys	P															
A Coloris	after death Director:	Certification:	3 Suicide 6 4 Homicide	Could not be determined	200. Flace	e of Injury - At ling, etc. (Spec	home, farm, s	treet, factor	y, office				(Street an own, State	nd Number or a)	Rural	Rou <i>te Num</i>	ber,
7	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edicai C	29a. Certifier 1154 C (Check only 2 M	ertifying Ph edical Exan	ysician: To the niner: On the b and man	e best of my kr casis of examin	nowledge, dea nation and/or i	th occurred	at the tir	me, date a pinion, de	nd place ath occu	, and due to th rred at the time	e cause(s e, date and	and manner d place, and c	as sta	led. he cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of	certifier	0.0	\	^	29	c. Licens	e number			29d. Da	te signed (Mo	onth, D	ay, Year)	-
	•		20 Name and address of	20_	completed cau	alle	23a) (Tuan) Print\	5	72C	43	5	1	104	/ 0	200	/
	Sta Regist		31. Date filed (Month Day	RFO	ulche		6565	N.	Chai	eles S	3+ 5	buted	209/	Bast	0	e Ca	1204

		-	For State Registrar	State of Maryland	Departme			giene 007 0	0065		
	Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Last Lawrence La. Facility Name (If not institution, give	R. Miner	4b. Ci	ty, Town, or Location	2. Date of Dea Month January	ath 3. Day Year	Time of Death		
	Funeral Director		210 44 3332	7. Age (In yrs. last	birthday) If Und	Baltimore der 1 Year If Under is Days Hours		Baltimore (, Year) 1946 Baltimore 9. Birthplace Country) Maryl	(State or Foreign		
	Ba-1 show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo		own or Location				nside City Limits		
	th with the 23a or 2 and be no	al Dire	101 W. Overlea	Ave.		Zip Code 21206		United Stat			
036	urs etter dea al', or items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		cedent of Hispanic Or pecify Cuban, Mexica 2 2 No Specify	rigin? (Specify Yes or No- in, Puerto Rican, etc.) :	14. Race - American In Black, White, etc. Specify: Whit			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Maryland Depertment of health and Mertall Hygiene. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other treumatic event, the Modical Examiner must be notified at once.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)			sual Occupation work done during mo Tuse retired) OUSE Mana	1	Publication			
land 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Roland Miner			El:	er's Name (First, Middle, izabeth Re	quard			
, Mar	and 2 sho alth and 27 le m		19a. Informant's Name/Relationship (7) Nathan Miner/				e. Baltimo	er, City or Town, State, Zip Cod re, Md. 2123	4		
timore	Pages 1 at the ment of He tent: If item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Eval	of Disposition (instance) of Fune oel- Be	eral Pal Air	1/4/2007		, Md.		
Ball	permit Deper Impor eny In	5 10	21. Signature Funeral Service Licens 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		and	Crematic	lity I Chapel On Services s cardiac or respiratory ar	8800 Harfor Parkville,	d Road Md 21234		
60,	Physician personned the process as the private and to the private as the private transit.	Physician/Medical Examiner	cal	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ce of):	<u>~</u>		Ons	et and Death
P.O. Box 6	The law requires that the death certificete to been signed by the ettending phys age 2 should be detached for use as the			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year				
ords, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the underlyin	ng cause given in Part		obacco use contribute to the ca	use of death? 4 Unknown		
		e Completed	25. Was case referred to medical			00.01	24a. Was autop perio 1 Yes	osy prior to comple death? 2 No 1 □ Yes 2 🔀	tion of cause of		
of Vit	Physicien: this certitional director.	To Be	examiner? 1 Yes 2 No		/Outpatient 3□	DOA Other: 4 1	lursing Home 5 KResid	dence 6 ☐ Other (Specify)			
ion	nding Peth. r: After to funera	atlon:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	January 2,2007 18	Bb. Time of Injury M	28c. Injury at Work? 1 Yes 2		eby Hanging			
Divis	To the Hospital or Attending Physicien: within 24 hours after deeth. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	>			Street and Number or Rural Rown, State) 101 W. GUEN Ovenlos, Md 2	.1236		
	n 24 hou	ledical		vsicien: To the best of my knowle iner: On the basis of examination and manner stated.							
	Vithi Vithi Con	Σ	29b. Signature and title of certifier	1 . 1		29c. License number		29d. Date signed (Month, Day,			
	2	<	90. Name and address of person who of Philip Militel		3a) (Type, Print)	1) 18776	11	January 4,2 Md 2109	>		
					101 1	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		V(X) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			

DHMH 17 Rev 1/2001

Jan 2, 2007 1844 hr 3

			For State Registrar	State	e of Mai	ryland / [artment of I				ien@ (007		
	Physicia		1. Decedent's Name (First, Middle	, Last)							Date of Dea Month	Day	Year	3. Time o	
	/Medic	al	CLAYTON	J.			1	MANNS			JANUARY	3,	2007	7:00	A.M.
	Examin	ér	4a. Facility Name (If not institution			CENTED		4b. City, Town, o	or Location of EST HI			4c. Co	unty of Death HARF		
1	194 A. 181	Can.	FOREST HILL HE. 5. Social Security Number	6. Sex		(In yrs. last bir	thday)	If Under 1 Year			8. Date of Birth		9. Birth	place (State	or Foreign
Н	Funeral Director		212-07-6602	1 ∑ M 2□			Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Pay 0/07/19	Year)	Cos	intry) ryland	, and the second
.15			Usual Residence of Decedent										- 110		
	arylan show	L	10a. State 10b. County			10c. City, Tow								10d. Inside C	ıty Limits 2 ∏ No
	Ba-f	ecto	PA York			Airvi	TTE					On Citizen	of Mhat Co.		- *
	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f show Jicel Exactinat must be cottified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Col									urrity:			
	eath ne 23	eral	703 Norris Road 17302 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							Race - Amei	ncan Indian,				
' O	r Iten	Fu	1 ☐ Never Married 2 ☐ Marr	Arme	ed Forces? Yes 2 ∐ No s, Give			f Yes, specify Cub	an, Mexicar	n, Puerto F	Rican, etc.)		Black, White	e, etc.	
036	ours a	þ	3 X Widowed 4 ☐ Divorced	If Year		II W		1 ☐ Yes 2🎇 No	Specify:			Sp	wecify: Wh	ite	
5-0	72 ho	Completed	15. Deceden (Specify only higher	's Education	eted)	16a	(Give	dent's Usual Occu kind of work done	during mos	at of workin	ng	16b. Kind	of Business/I	ndustry	
121	within ene. than "	mpi	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)		DO NOT use retire	id)			Cto	J Twa		
2	be filed within 72 hours after death with the Marylan ital Hygiene. Indoorber than "natural", or Iteme 23a or 28a-f show event, it a Medical Examinat must be notified at		17. Father's Name (First, Middle,	Last)			Ti	nman	18. Moth	er's Name	(First, Middle,		el Ind mame)	ustry	
an		To Be	George Manns	·					Mar	tha H	lammer				
Maryland 21215-0036	should nd Mer marke	-	19a. Informant's Name/Relations	hip (Type, Print	")	198	o. Maili	ng Address (Stree				r, City or To	own, State, Z	ip Code)	
	s 1 and 2 should f Health and Mer item 27 is marks other treumatic		Ronald Manns	(son)			703	Norris R	load -	Airv	ville, E	enns	lvani	a 17.	302
ore,	M O		20a. Method of Disposition 1	3 DRemoval	from State	20b. Place o	f Dispo	sition (Name of matory or other pla	ice)	D	ate	20c. Local	ion - City or	Town, State	
Ē	Peges ment of ant: If it ury or o		4 Donation 5 Other (S		IIOIII State	Garder		of Faith							
Baltimore,	permit. Pege Department of Important: If eny injury or once.		21. Signature of Funeral Service	Licensee	lns			2. Name and Addr 750 Bela							P.A. 1087
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one cause	that caused on each line	ne death. Do	not en	er the mode of dy	ing, such as	cardiac or	r respiratory ari	est,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition			neu	no	mic .						Sonset and	L)C
	/Medical Examiner		resulting in death)	Du	ue to (or as a	consequence								-	1
	× ×	_	Sequentially list conditions,	b	in to for sea	consecuence	offic.								
	led sit	nine	cause. Enter Underlying Cause (Disease or injury	3											
	al-tra/	Examine	that initiated events resulting in death) Last	C. Di	ue to (or as a	consequence	of):								
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	cal		d.											
9	ifficat g phy as the	e													
Вох	eath certifica attending ph I for use as th	N/ug	IF FEMALE: 23b. Was decedent pregnant		s, outcome o	f pregnancy	1 3[Ectopic pregnanc	cv			230	Date of deli		Year
	e deal he att	Physician/M	in the past 12 months? 1 Yes 2 No	4 🗆	Pregnant at t Unknown			Other (specify)	<i></i>				Month	Day	Teal
P.0	The law requires that the de lie has been signed by the : bage 2 should be detached	P.	9 ☐ Unknown Part II. Other significant condition	ns contribution	to death Kut	not resulting	in the r	nderwing cause g	ven in Part		23e Did to	bacco use	contribute to	the cause of	death?
S,	signe d be c	ğ	17 5 6	co M	1200	60	111 (110 1	ilderiyilig cadse g	/		_	es 2 🗆 !		_	Miknown
Sor	w requir been si should	etec	151	11-	10	/		1	Vien-	_	24a. Was	an Is	Ah Were au	topsy finding:	: available
Records,	has pe 2 s	Completed	Muscle	wtr	Curc	cras	cer	(ca C	M) EEC	جر	autop	sy	prior to death?	completion of	cause of
<u>a</u>		ဝိ	25. Was case referred to medica						26 Plac	a of Doath	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 🗆 No	
Vital	Physicien: this certific	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 Inpatien	t 2 🗆 ER/O	utoatie	nt 3D DOA	hor		ne 5 Resid		Other (Spec	cifv)	
of			27. Manner of Death	28a.	Date of Injury (Month, Day		Time o				28d. Describe h				
<u>io</u>	Attending I death.	atio	1 Natural 5 Pendir Pendir Pendir	gation	(Yes 2]No					
Division	or Attender de Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Place of Injurbuilding, etc.		arm, st	reet, factory, office	•	2	28f. Location (S City or Tow		lumber or Ru	iral Route Nu	nber,
۵	urs af														
	Hosp 24 ho Fune Fune	edical		Examiner: Orr		examination a		h occurred at the vestigation, in my							s)
	To the Hospital or Attenwibin 24 hours after deatl To the Funeral Director:	Med	29b. Signature and title of certifie		- Stat	-3.		29c. Licer	ise number			29d. Date s	signed (Monti	h, Day, Year)	
	- S - 0		1 1/1	156			ZAO.	PL	390	77		Tam	10.4.	3 7,	アア
A	11		30. Name and address of person	who completed	cause of de	ath (Item 23a)	(Type	Print)	10	<u> </u>		uni	rang	/ (0	V /
3	101		DR. PETER LOPR	ESTI -	1308	BUSIN	ESS	CENTER	WAY -	- ED	GEWOOD,	MD.	21040)	
(m	Sta		31. Date filed (Month, Day, Year,		32. Registra	r's Signature									
	Regist	rar	JAN 0 5	2007	Opas	A.C.	Strange .	200							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:30 AM ORRAINE RUTH MARTIN DI. DI. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CATON MANOR NURSING HOME CATONSVILLE Birthplace (State or Foreign Country) If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 □ M 290 F 213.26.8661 MDDirector Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 No BALTIMORE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5620 DAYBREAK IERR. 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural", or iten mortant: If item 27 is merked other then "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black White etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 🗷 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK <u>ک</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MAKER 7/14 GRADE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN GRAVES FRANCIS COATS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14RONE GRAVES (80N 5620 DAYBREAK TERR. BALTO. MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▶ Burial 2 □ Cremation 3 □ Removal from State RANDAUSTOWN, ND 4 □ Donation 5 □ Other (Specify) KING MEMORIAL 01.05.07 21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAYO, NATE PIKE, BAYO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Esophageal Due to (or as a consequence of): moneto disease or condition resulting in death) /Medical **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Months torive railure 10 physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1□ Yes Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State

29b. Signature and title of certifier

Shakunmala

JAN 05

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supra MD

32. Begistrar's Signature

29c. License number

9650 5 ANTIAGO

29d. Date signed (Month, Day, Year)

SUITE 110

COLUMBIA

21045

JAN 2

To the within 2 To the comple	
2010	
Sta Registr	

			Please Type or Print in Black Amend #18 Petaten (1863) april 127					00000
			1- State Registrar	Certificate of	Death		g. No. 2 U U /	00068
200	A A	Ä	1. Decedent's Name (First, Middle, Last)		2	. Date of Death Month	1	3. Time of Death
1	Physici /Medic		Joseph McGovern			January		6:20A ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of Dea	
			12101 Portree Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Rockv		. Date of Birth	Montgome	ery thplace (State or Foreign
	Funeral Director		052-32-4901 1MM 2□F 69 Yr	Months Days	s I Hours I Min I	(Month, Day, ctober 4,	Year) Co	w York
The same	era esticación com		Usual Residence of Decedent			CSODEL 1,	2,07	
	arylar show d at	-	10a. State 10b. County 10c. City, Town of					10d. Inside City Limits 1 X Yes 2 □ No
	he Ma 28a-f otifie	Director	Maryland Montgomery		ville	140	077 (1111	
	with t		10.1.0.1 Parameter	10f. Zip Code		10	g. Citizen of What Co	•
	ns 23 mus	Funeral	12101 Portree Drive 11. Marital Status 12. Was Decedent Ever in U.S.		0852 Hispanic Origin? (Speci ban, Mexican, Puerto Ri	fy Yes or No-	United St	erican Indian,
ယ	after or iter		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No			can, etc.)	Black, Whit	e, etc.
8	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1960	1 ☐ Yes 2 🛣 No	з эреспу:		Specify:	White
7	"natu	Completed	(Specify only highest grade completed) (6	ecedent's Usual Occi Give kind of work don ife. DO NOT use retir	e during most of working		6b. Kind of Business	/Industry
7	withir ene. than he Me	d L	Elementary/Secondary (0-12) College (1-4or 5+)	ivil Serva	,	1	nited Star	tes Government
<u>გ</u>	Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	LVII DULVA	18. Mother's Name (i			CO GOVERNMENT
lan	Ald be Alenta rked tic ev	ToB	Eugene McGovern		Mary Rien	er Rieme	er	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Stree	et and Number or Rural I	Route Number,	City or Town, State,	Zip Code)
ک ک	and lealth m 27 her tr				Drive, Roc			
altimore,	t of H it of H if ite or ot		20a. Method of Disposition 1t Burial 2	isposition (Name of crematory or other pl of Heaver emetery	Januar 1 Januar 2007		0c. Location - City or	
∄	it. Pa		4 □ Donation 5 □ Other (Specify) C 21. Signature of Funeral Service Licensee	emetery	ress of Eacility Robe	SI rt A. P	llver Spri umphrev Fi	ng, Maryland meral Home.
Ba	Department of the permanent of the perma		1 0 -: 1	Bethesda-	Chevy Chase Maryland 2	, Inc.,	7557 Wisc	neral Home, consin Avenu
b e	* - 34	7.	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Myocardial	nfarction				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of)					
	Examiner	_	Sequentially list conditions, b. Pneumonia					2 Days
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		nows Diagona			
,	oe executed cian and ourial-transit	Examiner	that initiated events resulting in death) Last c. C. CIFOILE ODSLITU Due to (or as a consequence of)		hary Disease			
760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit							
P.O. Box 687	rtifica ng ph as th	Physician/Medical	IF FEMALE:					
õ	ath ce ttendi or use	ian/I	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnan	су		23d. Date of de Month	livery Day Year
O	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify).			World	Day real
٦.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
rds	quires n sign ıld be	d by				1 ऋ Ye:	s 2 No 3 Pi	robably 4 □Unknown
O O	aw requir s been si 2 should	Completed				24a. Was an		utopsy findings available
ž	The I	lmo				autopsy perform 1□ Yes 2	ed? death?	completion of cause of 2 □ No
/ita	cian: ertifica ector,	Be	25. Was case referred to medical examiner?		26. Place of Death (
<u></u>	Physic this o	은	1 St Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outp	attern oldbox			nce 6 Other (Spe	cify)
Division or Vital Records,	Attending Physician: r death. ector: After this certificaby the funeral director, p	ion:	27. Manner of Death 28a. Date of Injury 28b. Tin (Month, Day Year) Injury 2 Accident investigation	iry W	ury at 28i ork? ⊒Yes 2⊒No	d. Describe hov	v injury occurred	
<u>ISI</u>	Atten death ector:	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm			f. Location (Stre	eet and Number or Ri	ural Route Number.
á	al or A s after at Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (C					
	thin 24	Medical	one) and manner stated. 29b. Signature and title of certifier		nse number		d. Date signed (Mont	
	5 ± 5 8		20. 00 11 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1		8426		nuary 3, 2	
	4		30. Name and address of person who completed cause of death (Item 23a) (Ty		0440	Ja	muary 3, 2	2007
2	1012		Galen Hallick, M.D. 10215 Fernwood		0, Bethesda	, Maryl	and 20817-	-1183
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1				
	Registr		JAN 0 5 2007 Street St.	Sparke				
DHI	MH 17 Rev 1/2	UU1	w ³ F	F				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 Year James Norman Miller January 3, 2:03 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√□ M 2□ F Months 80 Yrs. **Director** 220-12-7157 Sept. 16, 1926 Florida Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at Director MD Baltimore Nottingham 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 Funeral 74 Surrey Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 GYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž ☐ No Specify: þ SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natur any injury or other traumatic event, the Medical. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Debit Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Milton Miller Alice Rosalie Conway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma R. Miller- Wife 74 Surrey Lane Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/5/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wre of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, MD 21206 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumonia /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unicase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 ☐ No Division or Vital Records, P.O. the detached 9 Unknown 9 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No neral Director: / filled in by the f 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

within 24 hours a To the Funeral I

Registrar DHMH 17 Rev 1/2001

State

GOSNE

29b. Signature and title of certifier

Mar

31. Date filed (Month, Day,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 21:53 Jera Ine 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Maryland Medica timore niversty If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs 1₩ 2□F Months Hours 261-57-7295 Yrs 45 Director 1961 JUL 11, Washington Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD N/A Director Baltimore 1 √ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 North Howard St 21201 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced African American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumattc event, the Meg Elementary/Secondary (0-12) College (1-4or 5+) Writer Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judge Martin Louise Anderson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Glaize/Sister 4223 Chaste Tree Ct Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/2/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of the cause on each line. Immediate Cause (Final disease or condition resulting in death) VZV encephalitis **Physician** /Medical Due to (or as a consequence of) Examiner /AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending p IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical or Attending Physician: funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 TYes 2 TNo 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year)

P

Registrar

State

altimore MD 21201

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Greene

32. Registrar's Signature

lotnic

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year JANUARY 6:00 FM æ, Beverly Rose Meinecke 2007 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep. 8, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Months Min 1□M 2ĂF Days Hours Maryland Sep. 73 1933 212-30-3656 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No MD Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1705 Davinda Drive 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**%** If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 2√No Specify: Specify: 3 □ Widowed 4 □ Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James F. Butler Anna Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick M. Meinecke - Son <u>1705 Davinda Drive Finksburg, MD 21048</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Jan. 3, 07 | Baltimore, MD Metro Crematory 21. Signature of Juneral Service License Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): INTERSTITIAL LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2MNo 3 Probably 4 Unknown COLON CANCER 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury 1 Natural

The law requires that the death certificate be executed burial-transi Records, P.O. Box 68760, physician a the burial attending pl ed by the a signed to cate has been signated page 2 should b certificate Division or Vital the Hospital or Attending Physician: director this After n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral billed in bill death. To the Fun completely To the I within 2.

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be ပ

Examiner

Physician/Medical

ģ

Completed

Be

Certification: To

Medical

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

t: If Item 27 Is y or other tra

Department o Important: If any Injury or once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D 24034 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 7601 OSLER LOW. M. D. 21204 <u>YHTOMIT</u> DRIVE TOWSON MARYLAND

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician ${\tt P}^{\sf M}$ Gloria June 2007 12:38 Morehead January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9213 Howland Road Laurel Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 10 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1927 Months Days Hours Min. 1□M 2√F Washington DC 79 578-30-8930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 X No MD Director Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 9213 Howland Road 20723 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygene.
Instit I flem 27 Is marked outher than "natural", or Items 23s mit; If Item 27 Is marked outher than "natural", or other traumatte event, the Medical Examiner must any or other traumatte event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. <u>6</u> White 3 ☐ Widowed 4XXXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Clerk Motor Vehicles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Louise Prestele Marvin Brown Balderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. 9213 Howland Road Laurel, Marylnad Linda Morehead daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/2007 West Arundel Crem. Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 451 - / M00770 20707 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure years Due to (or as a consequence of) Hypertension 16 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit 16 years Diabetes Due to (or as a consequence of): Atrial Fibrillation 16 years the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown

Physician /Medical Examiner

and

with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Be Completed by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Certification: To 27. Manner of Death

1 ☐ Yes 2 ☑ No

1 🛛 Natural

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed physician attending properties for use as signed by the a d be detached f s certificate ha irector, page director this After within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

10

Medical

and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

1 Inpatient

28a. Date of Injury (Month, Day Year)

10

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

29c. License number

D0036371

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

January 3, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

2XXNo 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Banfer

Hospital:

3169 Braverton Street, Suite 201

Edgewater, Maryland

1 Tyes 24a. Was an

autopsy performed? 1□ Yes 2√ No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 A Residence 6 Other (Specify)

26. Place of Death (Check only one)

31. Date filed (Month, Day, Year) State Registrar JAN 0:4 2007 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	Maryland /	•	artment of H tificate of L			eg. No.	07	00073
	Physicia		1. Decedent's Name (First, Middle						2. Date of Deal Month Jan 3,	Day	Year	3. Time of Death
	/Medic	al -	Viola 4a. Facility Name (If not institution	Marie Mudg		-	4b. City, Town, or	Location of D		2007	nty of Death	2:30 A M
	Examin	er		aks Nursing			Clint		balli			George's
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last t	oirthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of Birth		9. Birth	place (State or Foreign intry)
	Director		578 56 1879	1□M 2∏X	89	Yrs.	Months Days	Hours N	July 8,	1917	New	York
	pur *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Maryli f sho	jo		ce George's	Acc	okee	k					1 ☐ Yes 2√ No
	r 28a	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	of What Col	untry?
	th with	Funeral Director	15519 Lane I	31vd			206	07			ed Sta	
	tems er.ms	uner	11. Marital Status	12. Was Decede Armed Force	s?	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin' n, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		łace - Amer Black, White	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Vac Cine	EXNo s:		1 ☐ Yes 2 TYNo	Specify:		Spec	cify:	White
号	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f show Ita Medical Evaminar must be notified at	ted	15. Deceder	nt's Education		a. Dece	dent's Usual Occupa	ation	warking	16b. Kind of	Business/l	ndustry
215	thin 7	Completed	Elementary/Secondary (0-12)	ost grade completed) College (1-4c	or 5+)		kind of work done of DO NOT use retired					
21	led wi lygien her th		12	(and)		Do	cument Ad		ator Name (First, Middle,		inanci	al
and	otal H ed otl	Be	17. Father's Name (First, Middle, Vernon VanAke						izabeth Ho		ano	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than "iraumatic event, Ita Me.	၉	19a. Informant's Name/Relations		1:	9b. Maili	ng Address (Street a		r Rural Route Number		wn, State, Z	ip Code)
	1 and 2 : Health ar tam 27 is		Loanne Coleman	n (Daughter)		98	0 Jeanies	Court	, Lothian,	MD 20)711	
J.	of Hei		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □ Removal from Sta			nsition (Name of matory or other plac		23, 2007	20c. Locatio	n - City or 1	Fown, State
Ĕ	Pages ment of I ent: If its ury or o		`4 □Donation 5 □ Other (Specify)	Arli	_	n Nationa		_			Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. Department must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury.		21. Signatur / of Funeral Service	M 0/-	-22-				Lee Funera Road, Cli		•	6633 Old 0735
	402.44		232 Part 1. Enter the disease, of	7	sed the death. D					· · · · · ·	ב עדו	Approximate Interval Between
68760,62	zate be executed XA Wedical Whysician and The burial-transit I Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence	e of):	Asu (m	210	eure			Onset and Death	
876	hysic the bu	lical		d								
P.O. Box 6	The law requires that the death certificate be executed to the steem signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal dea t at time of death		□Ectopic pregnancy □ Other (specify)				Date of deli Month	very Day Year
	s that ned b e deta	by PI	Part II. Other significant condit	ions contributing to deat	h but not resulting	g in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
ords	w require been sig should b	ted t							1 D Y	es 2 No	o 3 □ Pro	obably 4 Unknown
Il Records,		Completed							24a. Was a autop perfor 1 \(\triangle \triang	sy	prior to death?	topsy findings available completion of cause of 2 No
Vital	ysicien: is certific director.	Be	25. Was case referred to medic examiner?	Hospital:			Oth		Death (Check only or			
of	ding Phys th. After this funeral dir	To	1 Yes 2 No	28a. Date of I	njury 281	o. Time o	nt 3 DOA	4 Juliursii	ng Home 5 Resid			ory)
lon	Attending Physicien: r death. sctor: After this certificity the funeral director.	tion	1 Matural 5 ☐ Pend	/Ado oth	Day Year)	Injury		k? Yes 2∐No	1			
Division	Attendi	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of	Injury - At home, etc. (Specify)	, farm, st	reet, factory, office	-	28f. Location (S City or Tow		imber or Ru	ral Route Number,
Ö	rs after or rel Dir		0									
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 2 Medica	ing Physicien: To the be il Exeminer: On the basi and manner	s of examination	dge, dea and/or i	ivestigation, in my o	pinion, death	occurred at the time, o	date and place	ce, and due	to the cause(s)
	withi To t	Σ	29b. Signature and title of certification	T Ca			29c. Licens					h, Day, Year)
,	14		William	1 ame	5		73	مان ؟		740	لمعما	7,2001
	ω ^X '		30. Name and address of perso W. III Am T 31. Date filed (Month, Day, Yea	who completed cause		1100	Lung	of the R	isol Fort	WASH	lingtu	4 MD
	Sta Regist		JAN (4 2007	A Signature	1	franks			<u>-</u>		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1025 Month JAN **Physician** +1102 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL HARFORD BELAIR HEALTH & REHAB CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2 F C67-17-4901 Director -26 21 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other then "nature!", or Items 23a or 28a-f shov other treumstic event, the Madical Examinar must be notified. Abingdon 1 ☐ Yes 2 No Funeral Director ΔM 10e. Street and Number 10g. Citizen of What Country? Of. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21000 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify À 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be chreinei ဥ atherine cho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 ie eny injury or other treu 200. Place of Disposition (Name of cemetery, crematory or other place) Boxthorn Date | 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Fune and Chaef Belth 1 22. Name and Address of Facility
Evans Fune of Cha 07 21. Signature of Funeral Service Licensee Forest Hill, MOZICSO 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonan Immediate Cause (Final disease or condition resulting in death) **Physician** Stage hronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): ision of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivers 3 Ectopic pregnancy in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{No} \) Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No this certificate has 1 Yes 2FINO director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other. ပ္ 1 Tes 2 € No 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) seral Director; After thi filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d
To the Funeral Direct
completely filled in by 4 - Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

3

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Betty Irene Mathews 2007 2:30 A.M January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Summit Park Health Care Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 16, 5. Social Security Number 6 Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🔀 F Michigan 386-18-2917 83 Oct. 1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 21228 USA 124 Osborne Avenue Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 █ No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Stork Susan Gander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce D. Mathews Son 124 Osborne Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 3,2007 Catonsville, Maryland 4 Donation 5 Other (Specify) Metro Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signal To Ineral S 10 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐Unknown 1 Yes 24a Was an

Physician /Medical Examiner

and

for

permit. Pages 1 Department of H important: If ite any Injury or ot once,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

မှ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the first of Health and Mental Hyglene ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or here traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be Completed Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

After t

à

completely

death.

within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last 1 ☐ Yes 2D No

23b. Was decedent pregnant 25. Was case referred to medical examiner?

autopsy 1□ Yes 26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

7. Mann Death	
1 X Natural 2 Accident	5 Pending investigation
3 ☐ Suicide	6 ☐ Could not b
4 Homicide	determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

and manner stated.

Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

🖵 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred 1 🗌 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	1
29b. Signature and title	of certifie

29a. Certifier

3a) (Type, Print) and address of person who completed cause of

29d. Date signed (Month, Day, Year)

State Registrar

ulina 31. Date filed (Month, Day, Year) 32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Marylan	•				nental Hy	giene	U U /	UUU	110
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	пітіса	te of De	atri	2. Date of De.	Reg. No.		3. Time o	of Death
Phys	iciar			٠, ٦					Month	Day	2000	10:3	I O M
/Me Exar	dica		Robert W. Michai As Eacility Name (If not institution, give st.		1	4b. City	Town, or Lpc	cation of Death	01	4c. Co	upty of Death		· F
LX			Franklin Sough	2 Hospita		1	osed	ale			Baitir	nore	
Funer	al	1	5. Social Security Number 6. Sex	7. Age (In yrs.		If Unde		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthp Coun	lace (State	or Foreign
Direct	or	-	024-32-5668 Usual Residence of Decedent	W 20 F 04	Yrs.				9-5-1	942		MA	
land		-	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					1	0d. Inside C	City Limits
Marylan -f show		0	MD Baltimo:	re N	1iddl	- R 1	ver					1 🗌 Yes	a≱ No
h the			10e. Street and Number				p Code			10g. Citizen	of What Cour	itry?	
uth will		<u>e</u>	1520 Dornton Ave	enue			1220			USA			
er deg		Funeral Director		2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec	edent of Hispa ecify Cuban, M	nic Origin? (Sr Mexican, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Americ Black, White,		
be filed within 72 hours after death with the Maryland tial Hygiene. of other than "netural", or Items 23s or 28s-f show event, the Medical Examinar must be acquired as		S	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊋Yes 2 □ No If Yes. Give Year or Date Vietr	n a m	1 🗌 Yes	2₩ No S	pecify:		Sp	ecify: Whi	te	
2 hou			15. Decedent's Educa	ition	16a Dece	dent's Us	al Occupation	n		16b. Kind	of Business/Inc	dustry	
thin 7		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	ng most of work	ung				
ed will		5	12	1	Sect	urit	y Off				imore	Co.	Polic
B E D	d	Re	17. Father's Name (First, Middle, Last)				18.		e (First, Middle, Tardi		mame)		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italia	F	<u> </u>	Unknown 19a. Informant's Name/Relationship (Typ	e Print)	19b. Maili	na Addre	s (Street and		ral Route Numb		own. State. Zip	Code)	
125d			Marie Michaud -			•	•		Midd1	-			220
es 1 end of Health of Hem 27		-	20a. Method of Disposition		Place of Disponentery, cre	osition (Na	ame of other place)		Date	20c. Locat	ion - City or To	wn, State	
Pages ent of int: If it			1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	riso	-		1-9	-07	Owing	gs Mil	1s,	MD
permit. Pages Department of Important: If It	once.	T	21. Signature of Funeral Service Ligenses						dley-A				Home,
o ace	ä	1	J. J. J. J. L.)					Sprin		ad, 21		
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not en	$\overline{}$		11 -	1 1		1-1-6	Approxima Interval Be Onset and	tween
Physicia /Medic			Immediate Cause (Finat disease or condition resulting in death)	Esophagi	eal	an	er w	HIL	netast	21515	to lun	3	
Examin				Due to for as a conse	uence of):)	
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	uence of):								
cuted or ransit		Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events										
be exe		Ĭ.	resulting in death) Last	Due to (or as a consec	uence of):								
eath certificate be executed attending physicien and for use as the burial-transit		dical	d.										
CA CO certifii noding	:	a	IF FEMALE: 23	c. If yes, outcome of pregna	ancy					23d	I. Date of delive	erv	
Jeath atter		Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c		⊒Ectopic ⊒ Other (:	pregnancy specify)				Month	Day	Year
by the ache		hys	9 Unknown	9□ Unknown									
The Cords, F.O. BOX of The law requires that the death certificate has been signed by the attending sape 2 should be detached for use as	ľ		Part II. Dther significant conditions cont	nbuting to death but not res	sulting in the i	underlying	cause given in	n Part I.			contribute to the		
w requires been sign should be									10	Yes 2 N	¶o 3 □ Prob	ably 4	JUnknown
Hawr Has be	.	Completed							24a. Was	psv	24b. Were auto	psy findings mptetion of	s available cause of
The The Cate h		ဂ္ဂ	ear - g - company						1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No	
VICAL Sician: certifica		o Be	25. Was case referred to medical examiner?	ospital:	1550		Othor		th (Check only		70		
Physical Physical Control Physical Physical Control Physical Control Physical Physical Physical Control Physical	1		1 ☐ Yes 2 ☑ No	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time (28c. Injury at Work?		ome 5 Resi 28d. Describe			y)	
Attending r death.		at o	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		2 □ No					
I or Atter after dea Director	.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, s	treet, facto	ory, office		28f. Location (City or To		lumber or Rura	al Route Nu	mber,
Is after Ded							10000000	941.25 T					
Hosp 24 hou Fune		edical	29a. Certifier Certifying Phys (Check only 2 Medical Examin	cian: To the best of my known: On the basis of examination	owledge, dea ation and/or i	th occurre nvestigation	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	date and pla	id manner as s ace, and due to	tated. o the cause	(s)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, sade 2.		Med	29b. Signature and title of certifier	and manner stated.		2	9c. License nu	ımber		29d. Date s	igned (Month,	Day, Year)	
ة ∓ ≼ ∸			Donk 1	Quell	MI		RPG 1	0000	\circ	1/1	07		
1	X	-	lame and ad ress of person who con	npt cau f death (tte	n 23a) (Type	, Print)	-) /	7 ,	1.7	-1	1102	1
· ·	2)		Dr. Binh Nguyen	19000 Fran	1Klin	Squa	re V	vive 1	altimo	1e,7	ncl o	11231	/
	Stat	•	31. Date filed (Month, Day, Year)	Registrar's Sign	ature A	males I	5						

07-00028 Leon Ne lson, 3rd	t	Please Type or Print in Black Indelible In State of Maryland / Department of			ble.	and the total and the
	F	For State Certificate of eqistrar		Reg	No. ZUU	/ 000/
Physicia Medical Exami		Decedent's Name (First, Middle,Last) LEON THOMAS NELSON III		2. Date of Death Month Danuary 1, 2	ay Year 2007	3 Time of Death 2135 hrs
		la. Facility Name (if not institution, give street and number) 4. University Hospital	o. City, Town, or Location of Deatl Baltimore	n	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mir	_ `	MM/DD/YYYY) 9. Birt Foreig	n
Director	-	219-23-4470 1 XM 2 F 17 Yrs	Land Baye House Him	4-5-1	989 Co.	untry) MARYLAND
w any		0a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE				10d. Inside City Limits 1 X Yes 2 No
vith the Maryland s 23a or 28a-f show s notified at once.	Director	Oe. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	
th the N 23a or 2 notified		2918 WINCHESTER ST.	21216		USA	
r death wi or items must be	Funeral		Decedent of Hispanic Origin? (Ss., specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
2 hours after "natural", o	ā.	Wildowed 4 Divorced If Yes, Give Year 1 1	Yes 2X No specify: s Usual Occupation (Give kind of	work done 1	Specify: BLA 6b. Kind of Business/li	
6 72 hou un "nati cal Exa	leted		st of working life. DO NOT use rel		ob. Kind of Basinessin	industry .
5-0036 led within 72 Hygiene other than the Medical	Completed	7. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Ma	Jh iden Surname)	
21 pe fi ital red ;	Be	LEON T. NELSON, JR. 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing	BETH Address (Street and Number or	A. CAMPB		
MD 21 d 2 should I th and Mer n 27 is man	٦		WINCHESTER ST.			
Baltimore, MI permit Pages I and 2 Department of Health a Important: If item 27 injury or other traum			ion (Name of cemetery,		20c. Location - City or	
Baltime permit Pag Department Important:	-	4 Donardon 5 Other Specify: ARBUTUS MEN 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER. No.	IORIAL PARK 1-6	6-2007	BALTIMORE,	MARYLAND B A
		Jaath O. Horse 172	1-27 N. MONROE	ST. BALT	IMORE, MAR	YLAND 21217
Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a Gunshot Wound of Torso	e mode of dying, such as cardiac	or respiratory arresi	, snock, or neart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	iner	Sequentially list conditions, Due to (or as a consequence of): Due				
ed	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
be executed ician and urial - transit	핗	UNPENDED AMENDED				
Box 68760, death certificate be ex the attending physician of for use as the burial		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet	al death 3 Ectopic pregr	nancy	23d. Date of delivery Month	Day Year
30x 6 death cer e attendi	sici		er (Specify)			
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		acco use contribute to	
ds, Frequires				24a. Was an	24b. Were au	topsy findings available
tal Records, cian: The law requir certificate has been ector, page 2 should	Completed			autopsy perform 1 V Yes 2	ed? death?	completion of cause of ss 2 No
ital Rec ician: The l s certificate l	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient	26 Place of Death (Check 3 DOA Other Nurs		esidence 6 Other	
Division of Vital Records, rate or attendents of the law requir safer death. The law requir safer death of the this certificate has been seled in by the funeral director, page 2 should	n: To	27. Manner of Death 28a. Date of Injury (Month. Day. Year)		28d. Describe hor	w injury occurred	
Sion Attendi	cation	Natural 5 Pending Investigation 28e Place of Injury - At home, farm, stree	1 Yes 2 No			ral Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certific	3 Suicide 6 Could not be determined (Specify) Fast Food/Carry out	r, ractory, office building, etc.	or Town, Sta		
Division of Vital Records, P.O. Box 68760, within 24 hours after deep the Physician: The law requires that the death certificate be executed within 24 hours after deep the Physician: The law requires that the death certificate be executed To the Finneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transl	Medical (29a Certifier Check only 2 Certifying Physician: To the best of my knowledge, death occurrence 2 Medical Examiner: On the basis of examination and/or investigation and manner stated				
F S F O	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Mo	nth, Day, Year)
		Himilican Wiffield, MD 30. Name and address of person who completed cause of death (Item 23a)	J.O.IVI.E.			
H			Penn Street, Baltimore,	MD 21201		
S Regis		31 Date filed (Month, Day, Year) JAN 0 4 2007 32. Registrar's Signature	acks			
DI IN 411 47 7	1004					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #8,perFH,C871,9/6/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day JANUARY 2. **Physician** 2่ติด7 8:35 AM SWIOC 2014 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Center Towson If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1□ M 2 F Director 996 19 83P. 12. 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. a or 28a-f show be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director malteral 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a 8813 15.F permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. "natural", or items 23a Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must to gones. 31834 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify. 35€ Widowed 4 Divorced THEW Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 495 JAKS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be コシロのなしま Robins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21337 ROAD (COBSES (BWTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JAN. b. 3 ☐Removal from State Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) Door IMETERY 2007 22. Name and Address of Facility HAP J+ LAW EXPOSED HARFORD ROPE PARKY 21. I groupe of Ful first Service Licensee PARKY N. God 21334 RNA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List drily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine he law requires that the death certificate be executed burial-transit and A Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 88 attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown een signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an rage 2 s autopsy performa Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this after death.

I Director: After this id in by the funeral di 28a. Date of Injury 27. Mapner of D ath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 D 37254 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 BOON P. LIM. OSLER DRIVE TOWSON. MARYLAND M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 2007 Registrar

DHMH 17 Rev 1/2001

07-00030 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Walter A. Overton State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 2. Date of Death 3. Time of Death January 2, Day 2, 2007 **Medical Examiner** 0145 hrs stitution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Upper Cheasapeake Medical Center Bel Air Harford 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Min Director Hours 1 XM 1-3048 2 Country) Usual Residence of Decedent 10c. City, A LI Town or Location 10d Inside City Limits 28a-f show Yes 2 No notified at once. Director 10g Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian Black is marked other than "natural", or items atic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 Yes Widowed Yes 2 No specify. If Yes, Give Year 4 Divorced \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ges I and 2 should be titled within of Health and Mental Hygiene. s Name (First, Middle, Last 18. Mother's Name (First, Middle, Maide other traumatic event, Be (Street and Number or Rural Route Number, Method of Disposition Place of Disposition (Name of cemeter crematory or other place) Cremation 3 Donation 5 Other Specify. ture of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n **Physician** failure. List only one cause on each line Between Onset and /Medical a Gunshot wounds (2) of torso Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical physician a the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Year Day Pregnant at time of death Other (Specify, be detached for Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital. Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes Other 28a Date of Injury (Month Day Year) Jan 1, 2007 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot Natural 2305 hrs Pendina Yes 2 V No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 445 Meadowwood Road, Edgewood, MD determined (Specify) Other (specify) 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E January 2, 2007 las 30. Name and address of person who completed cause of death (item 23a)

DHMH 17 Rev 1/2001

State Registrar Tasha Greenberg MD

31. Date filed (Month, Day, Year,

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THEODORE PEPLINSKI Month a way 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, 10 min.

POSECIALE

If Under 1 Year II Under 24 Hrs. 8. Date of Birth
Days Hours Min. 2.24 - 1931 4b. City, Town, or Location of Death Examiner Square Ranklin 7. Age (In yrs. last birthday) HIMORE Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F 199-22-2523 75 Yrs. PENNSYLVANIA Director Usual Residence of Decedent 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show way Injury or other traumatic event, the Medical Examinat must be collised at once. 10a. State 10c. City, Town or Location MD BALTIMORE MIDDLE RIVER 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6706 UNIVERSITY DRIVE 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 [Syves 2 □ No If Yes, Give Year or Dates: 1949–56 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE ģ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN BETHLEHAM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LEO (SONTOWSKI) PEPLINSKI JOSEPHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOEL MULLER / DAUGHTER 6706 UNIVERSITY DRIVE BALTO, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 1-3-2007 CATONSVILLE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner tricula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the transit Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Physiclan/Medical Kenal ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Tetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 3 Probably 4 Unknown Be Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed death? 1 ☐ Yes 2 💢 No 1 Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. М 1 □Yes 2 □No investigation efter death Director; the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funeral D completely filled is 29a. Certifier Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and the to the causals) and francer as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ceptiler 29d. Date signed (Month, Day, Year) 29c. License number >28

Registrar

State

Theodor

Franklin Sq. dR. Baltimore, MD 21237

200

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1:45 P M Milton January 1, 2007 Wesley Parker 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2536 Overlook Glen Davidsonville Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □XM 2 □ F Yrs. 208-14-3460 81 Dec 16, 1925 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2536 Overlook Glen 21035 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. DXYes 2 □ No f Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Potomac Basin Group Elementary/Secondary (0-12) College (1-4or 5+) Association Insurance Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tra Parker Ethe1 May Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettijane Parker/wife 2536 Overlook Glen Davidsonville, Maryland 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crematory 1/4/2007 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Houses 1411 Annapolis Road Odenton, Maryland 21113 edina 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Swint and L Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 1 ☐ Yes 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Importants: If Item 27 ie marked other that any Injury or other traumatic event, Ina. 2006.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "naturel", or iteme 23a or 28e-f show the Medical Examinar must be notified at

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

þ

Completed

Be

٩

Examiner burial-transit P.O. Box 68760, the attending physicien The law requires that the death certificate be Physician/Medical as the l use ŏ signed by the a Records, 2 Completed Division of Vital Be ٤

Physician: this Certification: in by t

Hospital or Attending s efter death. pelli within 24 hours of To the Funeral

Ē

State

31. Date filed (Month, Day, Year)

Registrar

Medical

Mayner of Death

Natural

3 Suicide

29a. Certifie

4 \ Homicide

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

5 Pending investigation

6 Could not be

JAN 0 5 2007

determined

			_		26. Place of De	ath (C	neck only one	
1 🗌 Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	AOO	Other: 4 Nursing H	lome	5 Residence	6 Other
Date of Injury 'Month, Day Ye	ar)	28b. Time of Injury		28c.	Injury at Work?	28d.	Describe how inju	ury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ence 6 Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec 29b. Signa

28a. [

15 am 200 ann 10eg

29d. Date stined (Month, Day, Year)

I ac 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Man			lealth and M	•	_	00000
			1 - State Registrar		Cei	rtificate of L	Death	Reg.	No. UUI	00082
Н	Physici	an	Decedent's Name (First, Middle, La	,					Day Year	3. Time of Death
-	/Medic		Howard Maxwell 4a. Facility Name (If not institution, give	-		4b. City, Town, or	Location of Death	Jan. 3,	2007 4c. County of Death	11:27 A ^M
	LXamii	ici	Fair Haven Nur	sing Home		Sykesvi	11e		Carrol	
	Funeral		5. Social Security Number 6. S 212-05-0717	G-M 2015	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 14,	9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	1()L			Feb. 14,	1905 PA	
	ehow	_	10a. State 10b. County	1	0c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	28a-f	Director	MD Carrol 10e. Street and Number		Sykesv	ille 10f. Zip Code		100	Citîzen of What Co	**
	h with	io ie	7200 Third Ave.	#218		2178	4		USA	
	r deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.1		ispanic Origin? (Spe n, Mexican, Puerto I	crfy Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	j.	1 ☐ Yes 2 🔀 No	Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow he Mudical Exercities nate it in clittled at	Completed by Funeral	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occupa		hite 16b	. Kind of Business/l	ndustry
121	ne. han "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	0			
d 2	filed v Hygie other t	e Co	8 17. Father's Name (First, Middle, Last)	PBX I	Rep air man		(First, Middle, Maid	one Co.	
ılan	Mental Mental rked c	To B	Maxwell P	nillips			Grace	Thomas		
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturei, or iteme 23a or 28a-f ehow applying or other treumatic event, the Mudical Examinar must be notified at another.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	l Route Number, Ci	ity or Town, State, Z	ip Code)
e,	1 end Heelth em 27		Katherine Merric	k - Daughter	20b. Place of Dispo	osition (Name of	c Ave. Oc		MD 21842 Location - City or	
mor	Pages ent of nt: # it		1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con		Metro Cre	matory or other plac	Jan.		Baltimore.	
Baltimore,	Depertm Depertm Imports ony injui		21. Signature of Funeral Service Lice		-/ 27	2. Name and Addres	ss of Facility Society	of Marvla	artimore,	PID
<u>-</u>	\$0 E 5 8		11/m 11	acason		299 Frede	rick koad	Baltimor	e. MD ZIZ	
П			23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	erdial 1	ntarctio	n.			neuvs
香	Examiner		Sequentially list conditions.	b						
,	ped sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	ionsequence of):					
o T	ate be executed hysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
3760,	ate be hysicie he bur	cai		d.						
x 68	leath certificate k ettending physic I for use as the b	Physician/Med	IF FEMALE:	23c. If yes, outcome of	Oregonancy					
Вох	death death death death death	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O.	et the	hys	9 Unknown	9□ Unknown						
	The law requires thet the death certifics ate has been signed by the ettending phoage 2 should be detached for use as it	ρ	Par II. Other significant conditions	contributing to death but in the sports			en in Part I.	23e. Did tobac		the cause of death?
Division of Vital Records,	w requir been si should I	Completed		/ /	4,010.			24a. Was an	100000	topsy findings available
Re	The lav	шо	recent phenine) racc				autopsy performed	prior to death?	completion of cause of
ital		BeC	25. Was case referred to medical examiner?				26. Place of Death		INO TOTES	2 L NO
of \	Physic this cr	မှ	1 ☐ Yes 25 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier		9 Nursing Hor		e 6 □Other (Spec	cify)
ion	Attending Physician: r death. sctor: After this certific by the funeral director.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injury	Worl	yat k? Yes 2 □No	28d. Describe how i	injury occurred	
ivis	r Atter	ertification;	3 Suicide 6 Could not be determined		· At home, farm, str	reet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,
	urs eft erai Di	O								
	To the Hospitel or Attending Physician: within 24 hours elfer death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa- one)	nysician: To the best of r miner: On the basis of en and manner state	camination and/or in	h occurred at the time time of the time of time of the time of the time of the time of the time of the time of time of the time of time of the time of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License		1	Date signed (Monti	
}	,		· many				1849	Ja	nuary :	3 2007
	5		30. Name and address of person who William Tan M 31. Date filed (Month, Day, Year) JAN 0	completed cause of dear	th (Item 23a) (Type,	Print Road	Eldersho	urg MD	21784	4
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Acort 1		<u> </u>	, , ,	
	Regist	rar	JAN 0	4 200/ 1888	con fit	A STATE OF THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2:50 AM 2007 Pania Januar guline /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and # Examiner Genesis Franklin Woods Baltimore Rosedale | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 10-13-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Virginia Months 1 ☐ M 2 🕱 F 223-26-4599 85 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23s or 28s-f show other treumstic event, "I a Medical Examiner must be recitied at Parkville 1 Yes 2 No Baltimore **Funeral Director** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 3 Cedar Chip Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Drug Store Pharmacy Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be James Faust Julia Bevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a sortent: If item 27 is injury or other tret Jane E. Papania - Daughter 3 Cedar Chip Court Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 01-04-2007 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Si Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Chril. Leonard J. Ruck, Inc. Baltimore, Md 21214 23a. Part1. Enter the divease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart is ure. List only on-load se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Endstage Men /Medical Due to (or as a cons- uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. as IF FEMALE: use a 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Dectopic pregnancy jo in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 -NO funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 👺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier morelow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> MD 9/05 Franklin 32 Adgistrar's Signature

Salrare Dr.

State Registrar

JAN 03

DM

31. Date fited (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dvr 8863 1-3-07 vt State of Maryland / Department of Health and Mental Hygiene

00084

			1 - For State Registrar	State	or mary		artment of H rtificate of I			glene- ~ Reg. No.	, , ,	00004
			1. Decedent's Name (First, Middle, La	est)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		Jean Helen Quil	l.en					January		007	1:07 A M
	/Medic Examin		4a. Facility Name (If not institution, gir		umber)		4b. City, Town, or	Location of Death			inty of Death	
	Examin		Four Seasons N	ursina	Home		Bel Air			Har	ford	
	Funeral		Social Security Number 6.	Sex		n yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or Foreign ntry)
	Director		213-26-9519	1 □ M 2€□ F		77 Yrs.	Widitis Days	Tiodis inii.	March 2	8, 192	29 Mar	yland
7	2		Usual Residence of Decedent		- 1	On Circ Town and						10d. Inside City Limits
el co	t how	_	10a. State 10b. County		1 "	Oc. City, Town or L	ocation					1 ☐ Yes 2 ➡No
, W	Ba-f	cto	Maryland Harford			Churchvi					(117 . 0	
4	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
4	238	ra	202 Glenville R				21028	0	7 7 7	USA	Race - Ameri	ena ladina
9	te di	Funeral	11. Marital Status	12. Was De Armed F	orces?	r in U.S. 13.	Was Oecedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.))-	Black, White	
	0.0	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or	2 MNO live		1 ☐ Yes 2 🙀 No	Specify:		Spe	ecify:	White
3	tural		15. Decedent's E			16a. Dec	edent's Usual Occup	ation		16b. Kind o	of Business/Ir	
2 2	n and	Completed	(Specify only highest g	rade completed		(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	king			
7	the.	Ë	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home	maker			Own I	Tome	
ט די די די די די די די די די די די די די	Hyg ht.	Ö	17. Father's Name (First, Middle, Las	t)		1102110		18. Mother's Nam	ne (First, Middle			
5	2 Should be little within 7.2 hours arier death with his waryand and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-f show surnatic event, the Medical Examinar must be notified at	To B	Charles Emerson	Iley				Pauline	Elizabe	th Sev	vard	
	mari mati	=	19a. Informant's Name/Relationship			19b. Mai	ing Address (Street	and Number or Rui	ral Route Numb	er, City or To	wn, State, Zi	p Code)
2 5	permit. Pegas I and 2 should be lited within 72 thou's after death with the waryard in pegaturent of Health and Manial Hygione. Independent: if item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		Cheryl A. Landre	th/ Dau	ghter	202	Glenville	Road, Ch	nurchvil	le, M	2102	8
ָני ע	ten Hee		20a. Method of Disposition			20b. Place of Disp	osition (Name of ematory or other place		Date	20c. Location	on - City or T	own, State
	t: if i		11☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		n State		Memorial (1	-5-07	Bel Ai	ir Ma	ryl and
	orten Injur		21. Signature of Funeral Service Lice		/						LI, MA	Lyland
ם מ	Depe impo eny is		Stork 10	Morad	6	M	22. Name and Addre CCOMAS Fu: 317 Cokes	neral Hon	ne, P.A.	rdon M	/aral a	nd 21009
			23a. Part1. Enfer the disease, or col	mplications that	caused the						aryra	Approximate
			shock, or heart failure. List ont tmmediate Cause (Final	y one cause on	each line.		votic.	- 1	_			Interval Between Onset and Death
•	hysician /Medical	Н	disease or condition resulting in death)	a			TOFIC,	18Ears	Dise	ase	-	40 gr.
	Examiner			Due to	o (or as a c	onsequence of):						/
		P.	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (oras a c	onsequence of):						
1	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	ai-tra	Xa	that initiated events resulting in death) Last	C. Due to	o (or as a c	onsequence of):						
00/0	cate be executed physiclen and the burial-transit	dical		d								
0	p phy as the	edi										
× 1	ndin use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			75			23d.	Date of deliv	- /
	oeatr sette d for	cia	in the past 12 months? 1 □ Yes 2 ☒ No	4☐ Pre	gnant at tim		□Ectopic pregnancy □ Other (specify) _	/ 			Month	Day Year
ָ	by the	hys	9 ☐ Unknown	9□ Unk	nown							
	s ma med l	by P	Part II. Other significant conditions	,		1 1	underlying cause gry	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
cords	an sig	pe	Chronic Ob	Struc	true	Palm	ovary S	1sease	10	Yes 2□N	lo 3 Pro	bably 4 Unknown
္ပ	s bec	ojet					/		24a. Was		4b. Were aut	topsy findings available ompletion of cause of
֓֞֞֝֞֜֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֡֓֡֓֓֡֓֡֓	te he	Completed							auto perf	ormed?	death?	2 □ No
VITAI	tifice for, p	a)	25. Was case referred to medical					26. Place of Dea			100	20.70
5	S CBr	0 8	examiner?	Hospital:	Inpatient	2 ER/Outpati	ent 3 DOA Ott	> 4	ome 5 ☐ Res		Other (Spec	ufy)
5	1 train	n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Y	(ear) 28b. Time			28d. Describe			
0	ath. r: Aft e fun	ate	1 Natural 5 Pending 2 Accident investigation		min, bay r	unjury		Yes 2 □ No				
noisini	ar de cto	Certification:	3 ☐ Suicide 6 ☐ Could not determine	A 200. Flat	ce of Injury	- At home, farm,	street, factory, office			(Street and N	umber or Ru	ral Route Number,
5	s after safter s	Cert	- Tromose	00.	iding, die. (Ороспу						
	hour hour uner ly fille						ath occurred at the ti					
	To the Hospital or Attending Physician: The law requires that the deam certified to the Abours after deformable to the Abours after deformable to the Abours after deformable to the Abours after this centificete hes been signed by the ettending completely filled in by the funeral director, pege 2 should be detached for use as	edical	one)	and ma	anner state	d.						
	To To Com	Σ	29b. Signature and title of certifier	11/1	2	. ,	29c. Licens			29d. Date si	igned (Month	O7
			Joseph	04	Mes.	me hi		36 24	-6	1/	1	Φ_
	1		30. Name and address of person wh			th (Item 23a) (Typ	e, Print)	1-101	/ D	,	TIT	21060
	1		Robert W.		ne 1		Noes	162 Kg	JEN C	urnie	2 M	1 1000
	Sta		31. Date filed (Month, Day, Year)		Aegistrar's		000000					
	Registi	4:14	IAN A 2	2007 #	127	Del A	The second of the second					

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i

Funeral

Director

notified at

r than "natural", or Items 23a or 28a-f the Medical Examiner must be notifie

with the Maryland

Maryland 21215-0036

Baltimore,

JANUARY

attending physician and for use as the burial-transhould be detached certificate has

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

GERALDINE ROEMO

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12 State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD

TIMONIUM, MD 21093 2300 DULANEY VALLEY RD.

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) JAN 05 2007

29b. Signature and title of certifier

32. Registrar's Signature

07-00048 Gary Evan Ridgel	ly	Please Typ St	pe or Print intaction	n Bla	ack Indelible Department	Ink of F	. Ensure	All Copie Mental H	es Are Le ygiene	gible		7 00000
	E	- For State			Certificate	of E	Death			eg No.	<u> </u>	7 00088
Physiciai Medical Examin	n/	1. Decedent's Name (First, Midd	_{le,Last)} an Ridgely	,					2. Date of Dea Month January 2	Day 2, 2007		3. Time of Death 1715 hrs
		4a. Facility Name (if not institution 8283 Pond Court	on, give street and nu	imber)			City, Town, or I Millersville	Location of Death	1		. County of Deat	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birthday		If Under 1 Year	If Under 24Hrs	s. 8. Date of B		DD/YYYY) 9. B	rthplace (State or
Funeral Director		212-80-4797	1X M 2 F		46	· -	Months Days	Hours Mir	April	2/	1960 Fore	^{lg} Washington ountry) DC
	I	Usual Residence of Decedent							INDITI	_ 	17001	
w any	Γ	10a. State 10b. County			10c. City, Town or Lo	cation						10d. Inside City Limits 1 Yes 2 X No
land f shov	į	Maryland Anne	Arunde1				11ersvi Of Zip Code	11e		10a Citi	zen of What Co	
e Mary or 28a ied at	Director	10e. Street and Number						100				
Ath the	딅	8283 Pond Cour	rt 12. Was De	cedent	Ever in U.S. 13.	Was I	Decedent of His	108 panic Origin? (S	pecify Yes or N			rican Indian, Black,
leath v	Funeral	1 X Never Married 2 N	Married Armed F		X No	If Yes	, specify Cuban	, Mexican, Puerto	Rican, etc.)		White, etc	
after c	Ð.		vorced If Yes, Give Ye or Dates:	ar	1		es 2X No			1.5		ite
hours natur Exam	ed	15. Decedent's Education (Spe			durir			ion (Give kind of DO NOT use re		166	Kind of Business	Mindustry
36 nin 72 sthan "	bet	Elementary/Secondary (0-12)) College (1-4-01	,+,		Locksm	ith.		De	nt. of	Agriculture
5-003 ed withi ygiene other the	Completed	17. Father's Name (First, Middle	e, Last)	_				18 Mother's Nam	e (First, Middle,	Maiden	Surname)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygene tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	æ	George Willi	am Ridgely	7					es Mae			7 201
ID 21 Should and Me 27 is ma	-1	19a. Informant's Name/Relation				0	(et and Number or				te, Zip Gode)
Baltimore, MD permit Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ŀ	Sheree L.Mille 20a. Method of Disposition	r/sister	_	20b. Place of Di	spositi	on (Name of cer	Road,	Date		Location - City of	or Town, State
lore		1 Burial 2 X Crematic		rom St	ate crematory we s	t A	runde1	1 1	4/07		denton,	MD
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other ite	1	4 Donation 5 Other 5 21 Signature of Funeral Service	Specify: e Licensee		1	cema 22. Na	atory me and Address	s of Facilit Don	aldson			e & Cremator
Dep Dep Inju	1	DANIQUICA	amadas			P.A	. 1411	Annapo1	is Rd.	0den	ton, MD	
Physician		23a. Part I Enter the disease, of failure. List only one cause	e on each line. (🃉	aine	intoxicati	on c	omplicati	ing	or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	1.1	ive A	therosclerotic C	ardio	vascular Dis	seäse				Death
- Andrews		Sequentially list conditions,	b.	a ¢0/13	equentee ory.							
	ner	if any, leading to immediate cause. Enter Underlying Caus	Due to (or as	a cons	equence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	D - 1- /	a cons	equence of):							
and and transi	-		d						· .			
o, o, pe exv	edic	X UNPENDED	AMENDED	#23	a,27,28a-f,	perl ^V	E, g863,	1/24/07 T	Τ	Loc	Date of deliver	
Box 68760, e death certificate be the attending physical for use as the bur	an/Medic	IF FEMALE: 23b Was decedent pregnant in	u	, outco birth	me of pregnancy	Feta	ildeath 3	Ectopic pregi	nancy	23	Month	Day Year
x 6 th cert ith cert ith cert ith cert itendi	sicia	past 12 months?	nlynous '		time of death 5	Othe	er (Specify)					
Bc. Bc.	Physici	Part II. Other significant cond	J J J J I K	nown to deat	h but not resulting in	the un	derlying cause	given in Part I	23e Dio	tobacco	use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	þ	,			•		, ,		1 N	es 2	No 3 P	robably 4 🗸 Unknown
ds, require require seen si rould b	Completed								24a Wa	is an opsy		autopsy findings available o completion of cause of
e law e law e has i	mp	·								formed?		?
II Reministration, pa		25. Was case referred to media	cal	-			26.Plac	e of Death (Chec				
Vita lysicia this ce direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpati	ent 2 ER/Outpa	atient	3 DOA	Other Nurs	sing Home 5	Resid	fence 6 🗸 Ott	ner. Scene
n of ing Pt After Tuneral	n: T	27. Manner of Death		te of Inj		e of In		ury at Work?	28d. Describ	e how in	ijury occurred	
Sion Attend death. ctor:	ication:		restigation Fnd_				pm	Yes 2 X No	unknow		and Number or	Rural Route Number City
Division of Vital Records, tall or attending Physician: The law requir is after death. The Invercent. After this certificate has been seled in by the funeral director, page 2 should it.	Certific	de	ould not be termined (Specific		njury - At home, farm ound at home		, ractory, office	building, etc.	or Town	, State)	8283 Pon	Rural Route Number, City d Court
Lospit 1 to bour 1 to bour 1 to bour 1 to bour		4 Homicide 29a. Certifier 1 Certifying	Physician: To the b	est of r	av knowledge, death	occurr	ed at the time, o	fate and place, a	nd due to the ca	ause(s) a	and manner as s	tated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical E	xaminer:On the basi	s of ex	amination and/or inve	stigati	on, in my opinio	n, death occurred	d at the time, da	te and p	lace, and due to	the cause(s)
¥ 3 € 8	Me	29b. Signature and title of cert		1	/			se number				Month, Day, Year)
		4,	WI /	1			0.0	,M.E. 		Ja	nuary 3, 200	
		30. Name and address of pers	on who completed ca			Pen	n Street Ra	altimore, MD	21201			
15	tate			4								
Regis		JAN'U	الانالال وه	1000	and the state of	Mar sands						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} Day Physician Mary Leonarda Racioppa 11:00P M January 1, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laure1 Mariner Health & Rehabilitation Ctr Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🔀 F Yrs. 1915 178-22-1493 June 23, Director Penna Usual Residence of Decedent 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f show other treumetic event, the Medical Exarch at must be notified at 1 Yes 2 No Glen Burnie Anne Arundel Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 Crain Highway, 21061 Apt. 954 USA natural, or Itams 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If flem 27 is marked other then "natural; or item any injury or other treumetic event, the Medical Envir 1 ☐ Yes 2 🏖 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother Homemaker N/A Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Genell Antoinette Iacouangelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2501 Northridge Drive, Gautier, Miss. Joseph Racioppa 39553 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bayview Crematory, Inc. 1/3/07 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funecal Service Licensee Kevin E Ecker

22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Ave., Balto., Md.

238. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Syea Pnysician resulting in death) /Medical Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate ba exacuted Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 2 No 1 Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home P 1 Yes 25 No 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification:

Division of Vital Records, P.O. Box 68760, or Attending Physicien:

in by the funeral after death. within 24 hours a

State Registrar

30. Name and address of person who completed cause of death (Item 23a) 4333

29c. License numbe

1 🗆 Yes

🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Type Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

3 Suicide

29a. Certifier

Medical

4 - Homicide

Accident

JAN 0 4 2007

5 Pendina

investigation

6 Could not be

Laure Bow Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

07-00024 Errol Russell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rioi Russeii		1- For State Control of Pealth and Went Certificate of Death		eg. No oco a coco
Physicia	an/	Registrar 1. Decedent's Name (First, Middle, Last) Errol C. Russel1	2. Date of Dea Month January 1	th 3. Time of Death
/ledical Exami		er ERROLL C. RUSSELL 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		4c. County of Death
\rightarrow		University of Maryland Medical Center Baltimore	ani la più ani	What are a second of the base
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7 Age (In yrs. last birthday) Months Days Hours	Min. 4-16	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD.
any	1	Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location		10d Inside City Limits
land f show	ē	BALTIMORE BALTIMORE		1 Yes 2 No
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland etath and Mental Hygene tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	I Director	34 ARLINGTON AVE. 10f Zip Code 21223	,	U.S.A.
death wi	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Puerto Rican, etc.)	White, etc.
s after rral", o	þ	3 Widowed 4 Divorced in res, sive feat or page 11 fes. 2 V No specify or page 14 Divorced in res, sive feat or page 15 Jesus Occupation (Give k	and of work done	Specify: WhITE 16b. Kind of Business/Industry
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	use retired)	
5-0036 led within 72 hours afterlygiene other than "natural", the Medical Examiner	Completed	TORKLIFT OPERATOR		Packing Company
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Co	8 EDMUND CLARK RUSSEII CATH	S Name (First, Middle, ERINE 5 R	
nore, MD 2121; gges I and 2 should be fil nt of Health and Mental I: firem 27 is marked other traumatic event,	Tol	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num 12 GENMONT AVE. (2)	ber or Rural Route Nu	mber, City or Town, State, Zip Code)
ore, M es l and 2 of Health If item 2 her traum		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c, Location - City or Town, State
→ 6° 5 = -		4 Donation 5 Other Specify 21 St. ture of F rat ervice enses 22. Name and deless of Facility	1-5-07	HANOVER, MD.
Baltir permit B Departmenting		Daugherty Family Full	neral Home And Cre	ND 04400
Physician		23a Part I. Enter the discrete, or complication the caused the death. Do not enter the mode of dying, such as confailure. List only the cause of search	ardiac or respiratory ar	rest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
		Sequentially list conditions, b		
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated		
red Insit	Exar	events resulting in death) Last Due to (or as a consequence of):		
760, icate be executed physician and the burial - transit	Medical	X UNPENDED X AM\$\text{M}\$\text{D}\$\text{5}\text{2}\text{a},27,28a-f, perME, g865, 3/1/07 T	 Г	
760, icate be physic the burn the burn	/Mec			23d. Date of delivery Month Day Year
Box 687 he death certific the attending p	ician	2 Section of Specify) 1 Live birth 2 Fetal death 3 Ectopic past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy	World Day Four
. Bo he deat y the at hed for	Physician	Yes 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	art I 23e. Did	tobacco use contribute to the cause of death?
P.O ss that t gned by	by	Δ P	1 Ye	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ra after death. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed	leteo	24a. Was	
Reco The law ate has	dwo	du		ormed? death? 2 ✓ No 1 Yes 2 No
tal F cian: certific ector, p	Be C	25. Was case referred to medical 25. Place of Death		Residence 6 Other
of Vi g Physi fter this neral dii	ا ا	1 Yes 2 No 28a Date of Injury 28b. Time of Injury 22c. Injury at Work	Nursing Home 5 28d. Describe	how injury occurred
ion c tending eath. or: Af	ation	1 Natural 5 Pending 12/17/2006 unk.		
ivisior I or Attend after death Director:	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, e determined (Specify) House	tc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State) 32 S. Arlington Ave.
D lospital l hours uneral	Ser		FAITIMON	e, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	courred at the time, dat	e and place, and due to the cause(s)
F × F ×	Me			29d. Date signed (Month, Day, Year)
100		James G.C.M.E.		January 2, 2007
J. 1.		30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201	
	State	[[] [] [] [] [] [] [] [] [] [
Regi	stra	TEL VICTO S 2001 FRANCISCO April 1		

DHMH 17 Rev 1/2001 OCME 2006

ORIĞINAL

Please Type or Print in Black Indelible Ink. State of Maryland / Department of He	Ensure All Copies A	re Legible
State of Maryland / Department of Ho	ealth and Mental Hygic	ene2 0 0

		ype or Print in Black State of Maryland / D							
	1 - State Registrar		Certificate of		Reg. No.	. 0000			
Physiciar /Medica	I A N H	RICHARDS		2. Date of Month	Day, Year				
Examine	4a. Facility Name (If not institution, give s	treet and number)		r Location of Death	4c. County of De	ath			
	KESWICK HOME	17.4-4	Baltimon		N/A				
Funeral Director	5. Social Security Number 6. Sex	M OFT	Yrs. Months Days	Hours Min. (Month,	Day, Year)	rthplace (State or Fore Country)			
	Usual Residence of Decedent	90		Apr 2	29, 1916 Ala	abama			
ehow sdat	10a. State 10b. County	10c. City, Towr	n or Location			10d. Inside City Lim			
or 28a-f e	Maryland N/	A Balt:	imore City			1 XYes 2			
ial Hygiene. d other then "natural", or items 23a or 28a-1 show event, the Madical Exeminar must be notified at the Commission by European Director	10e. Street and Number		10f. Zip Code	011	10g. Citizen of What C	ountry?			
r Iteme 23s	700 West 40th St	2. Was Decedent Ever in U.S.	13. Was Decedent of H	211 lispanic Origin? (Specify Yes or	No- 14. Race - Arr	erican Indian,			
then "natural", or iter the Medical Examiner	1 XNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △	If Yes, specify Cuba	an, Mexican, Puerto Rican, etc.)	Black, Wh	ite, etc.			
Example 4	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:	1 □ Yes 2 ₩ No	Specify:	Specify:	White			
ygiene. her then "nature t, the Madical E	15. Decedent's Educ (Specify only highest grade	cation 16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working	16b. Kind of Busines	s/Industry			
then then	Elementary/Secondary (0-12)	College (1-4or 5+)	omemaker))	Own Resi	idenco			
Hygi ent,		110	omemaker	18. Mother's Name (First, Mide		rderice			
		Richards		Mary	Fowler				
It of Health and Mental Hygie If Item 27 is marked other to or other traumatic event, the	19a. Informant's Name/Relationship (Type	pe, Print) 19b.	. Mailing Address (Street	and Number or Rural Route Nur	nber, City or Town, State,	Zip Code)			
- r -	Conrad Richards			Cove, Collierv	ille, TN 381	_07			
Department of Heali Important: if Item 2 eny injury or other once.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. Place of cemeter	Disposition (Name of y, crematory or other place	Date	20c. Location - City of	r Town, State			
tment tant: jury o	4 ☐ Donation 5 ☐ Other (Specify)	Green		toryJan 4, 200	7 Baltimore,	Maryland			
Depar Impor eny in	21. Signatury of Funeral Service License	awson	22. Name and Addre	ss of Facility VIEDEFELD FUNER	AL HOME, INC	J.			
nysician Medical xaminer	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of				Interval Between Onset and Death 43 years			
ial-transit	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	if any, leading to immediate Cue to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury							
been signed by the attending physicien and should be detached for use as the burial-transit letted by Dhysician/Madical Examir		Due to (or as a consequence of	of):						
ding physe as the	IF FEMALE:	Bc. If yes, outcome of pregnancy							
by the attending phached for use as the	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	Day Year			
igned to	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause giv	en in Part I. 23e. Di	id tobacco use contribute	to the cause of death?			
en sig				1	☐Yes 2☐No 3☐F	Probably 4 Unkno			
his certificate has been s I director, page 2 should				24a. W au pe 1 Ye	stopsy prior to death?	utopsy findings availa completion of cause s 2 \(\text{No}\)			
ector. g	25. Was case referred to medical examiner?			26. Place of Death Check on	ly one)				
	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Out		er: 4 Nursing Home 5 R		ecify)			
is arier deam. el Director: After this of ed in by the funeral dir	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Ir		k? Yes 2 □ No	pe how injury occurred				
		28e. Place of Injury - At home, far building, etc. (Specify)		City or	n (Street and Number or F Town, State)				
he Funer pletely fill	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my knowledge er: On the basis of examination and and manner stated.	, death occurred at the tind/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	he cause(s) and manner a re, date and place, and du	s stated. e to the cause(s)			
within comp	29b. Signature and title of certifier	^	29c. Licens		29d. Date signed (Mor				
a	Myabelle Vac	tregar 73	DI	3657	January 2	,2007			
ŧ	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print) W 40 46 ST	REET, BALTI					
State	24 Date filed (Month Day Vens)	32. Registrar's Signature							

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Andrea Scanlon 2007 January 03 <u>11:</u>17 A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 22 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 216-68-9870 49 June 1957 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Brooklyn Park Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 603 Holy Cross Road 21225 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scanlon Thomas L. Sr. Mary Anne Andreau ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Shoe III 732 Winton Avenue, Glen Burnie, (son) MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 05 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Cremation Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21<u>122</u> 23a. Part . Enter the diseas shock, or heart failure. , or complications that List only one cause on o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Bleed-No Physician haurs 10422 /Medical Die o (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 mon Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2∏ No has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director; After this certificate 1□ Yes 20 or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22 Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deal 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanave! Street 3001 Sam Michae 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar **JAN 0** 5 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- ror	partment of Health and Mental Hygertificate of Death	iene 007 00091
	Obvojsi		Decedent's Name (First, Middle, Last)	2. Date of Deal Month	th 3. Time of Death
	Physici /Medic	al	(athorise M. Scott 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	03 2007 2:25 PM
	Examin	er	Riverview Care Center	Baltimore MD	Baltimore
E	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 215 14 5038 1 □ M 2√2 F 84 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Hours Min. 6.3 2.4	Year) Country)
	ס	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		10d. Inside City Limits
	be filed within 72 hours after deeth with the Maryland Hygiene. d other then "neturel", or items 23e or 28e-f show do other then "neturel", or items 23e or 28e-f show event, the Medical Examinar must be notified at	tor	MD Baltimore	Catonsville	1 □ Yes 2 □ No
		al Director	10e. Street and Number 101 Beechwood Avenue	10f. Zip Code 21228	0g. Citizen of What Country? USA
36	s after deet , or Items 2 aminer mu	by Funeral	1 ☐ Never Married 2 ☐ Married	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ♣ ★o Specify:	14. Race - American Indian, Black, White, etc. Specify: white
9-0	2 hour leturel			edent's Usual Occupation	16b. Kind of Business/Industry
21215-0036	within 7 lene. then "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired) Hairdresser	Beauty
and 2		Be	12 0 17. Father's Name (First, Middle, Last) Emil F. Saul	Maiden Surname) Meininger	
Maryland	d 2 should be f th end Mental I 7 is marked of treumatic ever	P.		ling Address (Street and Number or Rural Route Number	-
	1 and Heelth Sm 27 ther t		20a Mathed of Disposition 20b Place of Disp	36 Robinwood Rd, Dunda	20c Location - City or Town State
E	0 to 1		1 Burial 2 □ Cremation 3 □ Removal from State HOLY C Other (Specify)	ross Cemetery 01/08/07	7 Baltimore MD
Baltimore,	permit. Pag Department Importent: i any injury o		21. Signature of Funeral Service Licensee Victor P. Doda, Jr.	neral Home, Inc. altimore MD'21230	
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	octive Voloronas Dirice	re years
В	Examiner				
J.	uted d ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):		
), (0	icate be executed physician and s the burial-transit	I Examin	resulting in death) Last		
68760,	ficate by physical streets the control of the contr	edlcal	d		
.O. Box	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physiclan/M		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Ω.	uires that t signed by ild be detac	by	Part II. Dther significant conditions contributing to death but not resulting in the Hyperfection Asterioselection	underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 □ thinknown
Records,	e law require has been sly je 2 should b	Completed	Hy poqueid	24a. Was a autops	
a B	W		Deneuta	perfor 1 ☐ Yes	med? death? 2 1 Yes 2 No
f Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical saxaminer? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Wursing Home 5 Resid	
on of	ng ifter inel	lon: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		ow injury occurred
Division	tsn leath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		treet and Number or Rural Route Number, n, State)
	To the Hospitel or At within 24 hours efter of To the Funerel Direct completely filled in by	Medical Ce	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de, 2 Medicel Exeminer: On the basis of examination and/or		
	ro the vithin 2 ro the complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	. 21-0		Himsel Second	D17661	01-04-2007.
	4		30. Name and address of person who completed cause of death (Item 23a) (Type Purchased 7310 P	e. Print) Litclier Hylway + 508 C	blen Bornice, Md 21061
*	Sta Regist		31. Date filed (Month, Day, Tear) JAN 0 5 2007	le	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BENjamin Month Year SAUNIDERS 6:00 PM JANUARY 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOTCHE Baltimore Koad If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1**№** M 2□F 22946-9127 **Director** 11/36 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at angle. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits BaHimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Blac Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 6 ege (1-4or 5+) Elementary/Secondary (0-12) XVYS 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle Be rison tergerson 19a, Informant's Name/Belationship (Type. Print) Rural Route Nymber, City or Town, State, Zip Code) Batto 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/Zoo7 Dwings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Six a re of Funeral Service Licensee llstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Small Cell Cancer ONE YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burlal-tran Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical ed by the attending professional IF FEMALE: fyes, outcome pf pregnancy □Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Cardiomyopathy 1 Tyes 2XNo 3 Probably 4 Unknown Prostate 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ►No autopsy performed?

1 Yes 2 No certificate Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Elizabeth alice Guffiths, Nedal Decker D63950 Linvary 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH GRIFFITH'S OUTPANENT SERVICES WEINBORG FULLONG 401 NORTH BROADWAY BALTIMORE MARYLAND 21231 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 4 2007

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death

Cole			Mary Vi	nes		
me/Relationship (Type	e, Print)	19b. Mailing Address (Stre			or Town, State, Z	ip Code)
Simon / position Cremation 3 Rec Control C	moval from State	921 North St. Place of Disposition (Name of emetery, crematory or other p	lace)			
15 Kin.			Hgts. Ave.			
ne disease, or complicat failure. List only one	cause on each line.	h. Do not enter the mode of d	lying, such as cardiac or		e, Mary	Approximate Interval Between Onset and Death
nditions, mediate rlying injury c.	Due to (or as a conseq	uence of): Wyocaloi uence of):		ion		DAY
d.	Due to (or as a conseq	uence of):				
pregnant 23/ months?	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ectopic pregnar			23d. Date of del Month	very Day Year
tive Head	nbuting to death but not res	ulting in the underlying cause	given in Part I.		use contribute to	the cause of death?
nik Obst extensió	ruefive Cor	15 Discase		24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
red/to medical		/	26. Place of Death	(Check only one)		
No Ho h 5 □ Pending investigation	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury 28c. In		ne 5 🗍 Residence 8d. Describe how inju		cify)
6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, street, lactory, offic fy)	ce 2	8f. Location (Street a City or Town, Stat		ral Route Number,
		owledge, death occurred at the ation and/or investigation, in m				
title of certifier	+100	HC 29c. Lice	062850		ate signed (Mont	
k Vem	np red cause of death (Iter	Sivial	Hospital			
		ORIGINAL				

00093

3:52 PM

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2□No

Maryland

2067

Black, White, etc.

Specify: Black

Reg. No.

2. Date of Death

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Frank

30. Name and address of person who complete

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

ype or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#1 per PHYS. G863.174/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wavne M. Shreffler Day , 2 0°0 7 5:00 Av January Wayne M. Schruffler 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dundalk Baltimore Heritage Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Bir Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 ☐ F Months 72 216-32-6567 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21222 48 Yorkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent Grempler Realty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gladys Taylor Russell Shreffler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 3946 Schroeder Avenue, Perry Hall, MD 19a. Informant's Name/Relationship (Type, Print) Beverly Covey - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1 - 4 - 07Oak Lawn Cemetery Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Bradley-Ashton FUneral Home 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SOPHAGEAL CANCER Sequentially list conditions, lary Laurey to memorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TES MELLITUS EIBRILLATION IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney Death 28a, Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Maturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

burial-transit tha Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician as the the been signed by filled in by the funeral director, page 2 after death. Director: After within 24 hours a To the Funeral L

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

ပ

Examiner

Physician/Medical

by

Completed

Be

٩

Certification:

Medical

State Registrar

29b. Signature and title of certifier

Funeral

Director

If itam 27 is marked othar than "natural", or itams 23a or 28a-f show or other traumatic evant, the Modical Examinar must be notified at

al Hygiene. d othar than "

permit. Pages 1 and 2 should in Department of Health and Men Important: If itam 27 is marke

injury

Physician /Medical Examiner

ould be filed within 72 hours after death with Mental Hygiene.

Baltimore, Maryland 21215-0036

the Maryland

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 rn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bayview Medical Center Baltimore Hours Min. 8. Date of Birth (Month, Day, Year)

June 7,1930 If Under 1 Year 7. Age (In yrs. last birthday **Funeral** Days Months 1 ☐ M 2 ☐ XF 213-26-9767 76 Director Tennessee Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 □Yes 2 XNo ns 23a or 28a-f sh must be notified Dundalk Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 21222 Apt 217 7801 Penninsula Expressway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event. The Macric of Once. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Smith Preston McLaughlin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 402 Piney Point Drive West, Perryville, MD. 21903 Daughter Tammy M. Sindall 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery Rosedale, Maryland 5,2007 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Pulmonary Disease Chronic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner found Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1∐ Yes 2 No 2 □ Na or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 enpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Natural Injury al Director: A 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MO 000 30. plane and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE, MD 4940 DAMING 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan 2, 2007 **Physician** Aida C. Seeley 8:37AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 8, Nov. 8, Towson Baltimore Gilchrist 5. Social Security Numbe 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1913 1 □ M 2√2 F 072.12.0308 93 New York Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2☐No Director Florida Palm Beach Lantana 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7020 Half Moon Circle Apt 507 33462 Funeral USA death \ permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other traumant. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angela Bonino Joseph Bovani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Centerville Road Blairstown, NJ 07825 Frank Seeley (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 1-3-2007 Catonsville, MD 21. Signature of Funeral Service Lipersee ²² Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse uence of): Physician weeks /Medical Examiner UVIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and A ng physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Division or Vital Records, P.O. certificate has been signed by the a rector, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> ment 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause death (Item 23a) (Type, Print) onles St. Bolto. Md 2120% 6701 AMC

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Registrar's Signature

ŭ	ł	Fu Dir
Iltimore, Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	artment of Health and Mental Hygiene.

a.m.

10:40

2007

JANUARY

Physician /Medical Examiner

Records,

Division or Vital

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Louis Carmen Storino January 2007 10:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Baltimore County Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 17,1920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) neral Days 86 333-14-5560 Yrs ector Chicago, Il. Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits at 1 ☐Yes 2 No in "natural", or Items 23a or 28a-f sh Medical Examiner must be notified Director Maryland Baltimore County Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 6 Breezy Hill Court Apt. D United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXX es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker New Homes 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgilio Storino Mary Beatrice Scala ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Ellen Hess (Daughter) 10100 Charington Road Cockeysville, Maryland 21030 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State injury or 07 Evans Funeral Chapel Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr. P.A.
2325 York Road, Timonium, Maryland 21093 21. Signature of Funeral Service Licenses Depa Impo any ir cera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No he perforr 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 3721 2/07 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			1 - State Registrar	,	C	ertificate of	Death	Reg. No. 2007 0003			
κ.	Physici	an	1. Decedent's Name (First, Middle, Las	st)		, 11	L-	2. Date of Do	eath Day	Year	3. Time of Death
	/Medic		William		Sto	ver- Hur		Januar	y a	2007	0109 M
	Examir	er	4a. Facility Name (If not institution, give	e street and number)	Maca	4b. City, Town, o	r Location of Death	, ,	4c. Coun	ity of Death	
-	Funeral		5. Social Security Number 6. S	ex 7. Age (In)	rs. last birtho	ay) If Under 1 Year	I Under 24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Foreign
н	Director		215-73-2256	[X M 2□ F	1 Yrs	Months Davs	Hours Min.	July1	5 , 2005	Mar	vland
	pu ,		Usual Residence of Decedent	1100	Ch. Town	- Location					104 114- 0%-11%-
	show	5	10a. State		City, Town o	ssex					10d. Inside City Limits 1 ☐ Yes 2√ No
	the M 28a-f notifie	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1029 Mace Av	enue		2122	1		USA	1 1111at 000	, y .
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or N	o- 14. Ra	ace - Americ	
9	after or ite		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	nican, etc.)		lack, White,	
21215-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		_				oify: Wh:	
<u>5</u>	"natı "natı	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1 (6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	durina most of work	king	16b. Kind of	Business/In	ndustry
12	withii lene. than	뼚	Elementary/Secondary (0-12)	College (1-4or 5+)		/a	/		n/a		
Q	i filed I Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)			/ 4	18. Mother's Nam	e (First, Middle	e, Maiden Surna	ame)	
<u>a</u>	should be fand Mental Fand Mental Fandswed of umatic even	To B	William Stove	r			Sabri	.na H	unt		
Maryland	2 should be filed v n and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship (Type. Print)	19b. N	lailing Address (Street	and Number or Ru	ral Route Numi	ber, City or Tow	n, State, Zij	p Code)
	D # C #		Rose Guy / Au			08 North					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 25☐ Cremation 3 ☐	Demoval from State	cemetery,	isposition (Name of crematory or other place	ce)	Date	20c. Location	,	,
ti	. Рад tment tant:		4 □ Donation 5 □ Other (Specifi	y)	Bayvı	ew Cremat		707	Balt	imore	e MD
Bal	permit. Departm Importal any inju		21. Signature of Funeral Service Licer	nsee /	_	22. Name and Addre	ss of Facility 30	00 Mac	e Ave.	Balt	timore MD
			23a. Part1. Enter the disease, or com	plications that caused used	leath Donot	Connelly				SSEX	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	- 1	A	ig, ocorr do cardido	or reophatory	arroot,		Approximate Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	a		Momaly				-	18 months
	Examiner			RSV by	mahir	litic					9 days
	- A	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of)						·
10	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Anoxie	brain						6 weeks
9	e exe		resulting in death) Last	Due to (or as a con:	sequence of)	.) '					
9,409,489	icate be executed physician and s the burial-transit	Medical		d							
	± 00 €		IF FEMALE:	23c. If yes, outcome pf pre	eanancv				224 [Date of delia	1001
Вох	leath cer attendin I for use	Physician.	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	У			Date of deliv Month	Day Year
P.O.	w requires that the d been signed by the should be detached	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown							
σ,	s that ned b		Part II. Other significant conditions of	ontributing to death but not	resulting in th	ne underlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
ğ	equire en sig ould b	ed b	Ex 34 Week in	fant respir	actor	1 Insutto	ciency,	1 🗆	Yes 2 No	3☐ Pro	bably 4 ☐Unknown
တ္မ	law re as bee	plet	ventilator de	oendent.		•		24a. Wa	s an 24b	o. Were aut	opsy findings available
Œ.	The ate has page	Completed by						perl 1∐ Yes	formed?	death? 1 ☐ Yes	2No
/ita	cian: ertific	Be (25. Was case referred to medical examiner?	Harriet . /			26. Place of Dea	th (Check only	one)		
or Vital Records,	Physi this c	은	1 ☐ Yes 20 No 27. Manger of Death	Hospital: Impatient 2 28a. Date of Injury	2 ER/Outpa		4 🗀 Nursing H		sidence 6 🗆 O		ify)
U	ding J. After funer	io	1 Natural 5 ☐ Pending	(Month, Day Yea	r) Zob. Tili	ıry Wor	yat k? Yes 2∐No	Zou. Describe	how injury occi	urred	
Division	Atten death octor: y the	ficat	3 Suicide 6 Could not be		At home, farm		700 2	28f. Location	(Street and Nun	nber or Rur	al Route Number,
Ε	al or / after I Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)			City or To	own, State)		
	ospita hours unera iy fille		29a. Certifier Certifying Ph	nysician: To the best of my	knowledge, o	leath occurred at the ti	me, date and place	, and due to the	e cause(s) and i	manner as :	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	one)	niner: On the basis of exan and manner stated.	miadon and/			ireu at the time			· ·
	With To 1	Σ	29b. Signature and title of certifier	1		29c. Licens			29d. Date sign		
	17			Tuneth MO			5-000		Janu	ary 2	,2007
	7		30. Name and address of person who	completed cause of death (Item 23a) (Ty	4 4	Batimon	CO MAN			
	Sta	ate.	Marissa Prunett	82. Registrar's S	ignature	Olfe St.	IN HIMMO	e, IVID	0168		
	Regist		.IAN 0 3 200	1 Danse A	y So	nde					
			JAIN V O COO	340	- 5						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1_ For State	State of M		nd / Depa		of H	ealth and	Mental Hy	gien	2007	00099
			1. Decedent's Name (First, Middle, L.	ast)			rimoate	0, 1	Joann	2. Date of De	Reg. No	D	3. Time of Death
	Physici		Milton L.	Sommers	111					Month	Da	Year	9.05 AM
	/Medic Examir		4a. Facility Name (If not institution, gi	ve street and number,)		4b. City, 1	Town, or	Location of Deat	h	40	. County of Death	1
			Franklin Sq	uare H	OSDÍ	tal	7	30	bedali	5	٢	Balti	MORE
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir Month, Da Sept.	rth ay Year	9. Birth	nplace (State or Foreign Intry) ryland
	Director		219-70-3259	TO M ZOF	50	Yrs.				Sept.	9,1	956 MA	ryıand
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Mary	ţ	MD Baltir	nore		Esse	ex						1 ☐ Yes 2122No
	r 28a	Director	10e. Street and Number				10f. Zip	Code			10g. C	itizen of What Co	untry?
	ours after deeth with the Maryland rel', or iteme 23e or 28s-f ehow Examine must be notified at	ai D	2221 Corsica	Road			21	221			US	SA	
ર્સ	eep .	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	0-	14. Race - Amer Black, White	
7 8	s afte	Y.	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 TYPes 2 ☐			1 ☐ Yes 2		Specify:				hite
1 Hilton 21215-0036	"naturel", or iteme	Completed by Funeral	15. Decedent's E	Year or Dates:		16a Dece	ident's Usua	I Occupa	ation		16h	(ind of Business/	ndustry
7 5	within 72 ho ene. then "natur	plet	(Specify only highest gi	rade completed)	F.\	(Give	kind of won DO NOT us	k done d e retired	ation luring most of wo)	rking			
75	d wift	EO	Elementary/Secondary (0-12)	College (1-4or	3+)	Comp	puter	Dr	after		AL	Inc.	
2 S	a file a Hy d oth	Be	17. Father's Name (First, Middle, Las	t)						ne (First, Middle			
E S	Ment Ment arked	10	Milton L. Son	nmers Jr					Dolore	es V. S	Silw	ick	
SOMMERS	permit. Pages 1 end 2 should be filed withir Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, the Magnee.	16. 5	19a. Informant's Name/Relationship				_				-	or Town, State, Z	
اه کے اه	1 end leelth lm 27 ther t		Jeanne VanCa	amp	20b 8	222	21 Co	rsi	ca Road	Balti		e MD 2	
O E	ages nt of h		1 ☐ Burial 2 XCremation 3 [Ba	emetery, cres	matory or ot	ner plac mat.	ory 1/6	5/07		timore	
SOR Baltimore.	if. Partmen		4 Donation 5 Other (Spec										
8	Department of the partment of		Vaturet O	Reus								e. Bali _Essex	imore MD
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the deat							ESSEX	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_									Onset and Death
	/Medical		resulting in death)	a. Due to (or as		Sequence of):	10212						
	Examiner		Sequentially list conditions.		Lmo								
100	slt s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	3 901 560	uurisa of):							
1	secufed and I-transit	xam	that initiated events resulting in death) Last	cDue to (or as	a consec	mence of):						-	
760.	te be execufed ysicien and te burial-transit	calE		·		,							
687	w ~ w			d			-						
Box 68	eath certificat ettending phy I for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75					23d. Date of deli-	/ery
m.	death e ette	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pre □ Other (spe					Month	Day Year
O.	thet the de ed by the deteched	hys	9 ☐ Unknown	9⊡ Unknown									
Ś	res the igned be de	by	Part II. Dther significant conditions	contributing to death t	out not res	ulting in the u	inderlying ca	use give	n in Part I.			5	the cause of death?
or o	w requires f been signe should be	eted	Chabetes				-			1 🗆 '		No 3□Pro	
ခိုင	e law hes b	mple								24a. Was autop		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
<u></u>	r: Th icete r, pag	S								1 ☐ Yes		1 ☐ Yes	200 No
, ₹	siciar certif irecto	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	20	IED/O		Othe		ath (Check only o		- F0: 40	
ठ	g Phy er this eral d	n; To	27. Manner of Death	1 Inpati 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o		Bc. Injury Work	4 🗀 1401 3/11g T	28d. Describe		6 □Other (Spec	iry)
<u>.</u>	ttending death. ctor: Afte / the fun	atio	1 Natural 5 Pending 2 Accident investigation		ly Year)	Injury	м		? ′es 2 □No				
Division of Vital Records, P.O.	er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of In building, e	jury - At h	ome, farm, str	reet, factory,	office		28f. Location (: City or To	Street a	nd Number or Ru	ral Route Number,
۵	ital o irs aft ral Di				. , . ,								- A
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be deteched for use as the	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of	of examina	wledge, deat ition and/or in	h occurred a vestigation,	it the tim in my op	e, date and place inion, death occu	, and due to the irred at the time,	cause(s date an	s) and manner as d place, and due	stated, to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner st	a(80.		29c.	License	number		29d. Da	ate signed (Month	, Day, Year)
	ĕ→≮→		V11200	11110	MT	>	Q	F	000			11.17	-
	()		30. Name and address of perso	completed cause of	death (Iten	n 23a) (Type.		-		1		11111	
94	7		DR Yodit Me	ausse.	9	000	FRan	Kli	n 89. c	te. Ba	His	lore. MD	21237
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture	D 5						
	Registr	ar	JAN 0 3 200	1 129 100	150	15000	4.0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Dorothy Margaret Timanus 01 04 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oak Crest Village - Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🗙 F Director 93 02/21/1913 213-03-5971 10c. City, Town or Location 10a State 10b. County 28a-1 show traumatic event, the Mudical Examiner must be notified at Director Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11321 Glen Arm Road 21057 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married naturei', or Ŷ 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 8 Inspector Bendix Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fa and Mental H Joseph Jarboe Frances Yienger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other tracents. Dorothy M. Dunsmore 6515 Mount Vista Road - Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Evan.Ch.Cem. 01/06/2007 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee assahn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aspiration pneumonia

Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner dementiq of Alzhemer's type end-stage

Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) P.O. I 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by peripheral vascular disasse 24a. Was an 1 ☐ Yes 2010 Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Other: Certification: To 1 Yes 2 N 4 Tursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Walther Boulevard, Parkville, MD 21234

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

1 ☐ Yes 2 🙀 No

Maryland

White

2:35 AM

Year

2007

State Registrar

4 Homicide

29b. Signature and title of certifier

Etosho Oxon MO 31. Date filed (Month, Day, Year)

JAN 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29a. Certifier

Medical

DHMH 17 Rev 1/2001

the

29c. License number

D61785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan		nt of Health and te of Death	Mental Hygier	Z 11 1 1 1 1	00101
	Physici	an	1. Decedent's Name (First, Middle, Last	e Than	2	10 0, 204	2. Date of Death		3. Time of Death
	/Medic Examin	al	BLTMU C 4a_Eacility Name (If not_institution, give			y, Town, or Location of Deat	bruary	Pay 2007 4c. County of Death	1. 8.10 AM
	LAAIIIII	(C)	Good Samar	itan Hosp	ital I	atinor	8. Date of Birth	a Birt	hplace (State or Foreign
il de	Funeral Director		4620-5211	x 7. Age (In rs.	Yrs. Months			ar) Qo	ary and
	yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	the Mar	ector	ND 10e. Street and Number	J.	Soltimo	ip Code	10g. (Citizen of What Co	1 XYes 2 □ No
	23a or	ai Dir	3211 Gibbons	Avenue		21214		USA	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show strip Injury or other traumatic event, the Medical Examinar must be inclifted at ances.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 25 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
15-0036	"natura	leted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Us (Give kind of v	ual Occupation rork done during most of wo use retired)	orking 16b.	Kind of Business/	Industry
2121	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nu	rse	H	ealth	care
land	ould be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)	\ <		18. Mother's Na	me (First, Middle, Maid	en Sumame)	
Mary	2 should and Men is marke raumatic	-	19a. Informant Name/Relationship (7	41 4	19b. Mailing Addre	ss (Street and Number or R	ural Route Number, Cit	y or Town, State, 2	Zip Code)
a)	es 1 and of Health fitem 27 r other tr		a. ethod of Disposition		Place of Disposition (No cometery crematory or	1 DOOD S # ame of other place)	1/10-	Location - City or	Town, State
Baltimor	permit. Pages Department of important: If It Important: If It any Injury or o		Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemoval from State	Nationa	(Conseten	16107 P	altimo	ore, MD
Bal	permit. Departr Imports sny Inj		21. Signature of Funeral Service Licens	Siw	You	1 Corl			Services 1212
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the deat one cause on each line.	h. Do not enter the m	ode of was such as cardia	c or respiratory arrest,	Devile Second	Approximate Interval Between nset and De th
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conseq	juence of):	pois			less thou
*	Examiner	e.	Sequentially list conditions, if any, leading to immediate	b. Coronan Due to (or as a conseq	Juence of):	ery desi	Corl		48 nous
B.	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Unage of):	V			
68760,	icate be executed physicien and s the burial-transit	edical E		d	usinos diy.				
-			IF FEMALE:	23c. If yes, outcome of pregna	ancy			23d. Date of del	iven/
P.O. Box	iaw requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 □Ectopic			Month	Day Year
	ires that the de signed by the a d be detached f	Ď	Part II. Other significant conditions of	entributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacc		the cause of death?
Records,	iaw requir as been si 2 should	Completed					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	reician: The law s certificate has t lirector, page 2 s	е Сош	OF Management and the modified				performed 1 Yes 2 2	death?	2.4
of Vital	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 X Impatient 2	ER/Outpatient 3□ I	Other	ath <i>Check only one)</i> Home 5 Residence	6 □Other (Spe	cify)
o uc	0 0 0		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	1	ome, farm, street, fact		28f. Location (Street City or Town, St		ural Route Number,
	Hospita 24 hours Funera tely fille	edical C	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	o(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Med			00011 2	9c. License number	/ 29d. I	Date signed (Mont	th, Day, Year)
			29b. Signature and title of certifier 30. Name and address of person who	completed cause of death (the	m 23a) (Tilana Brian) (25000	Ja	nucery	1012001
	4					allimere	/ Kd-	2123	59,
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	a.			

Registrar
DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Glenn Thompson

State Registrar 29b. Signature and title of certifier

moolee

Brocke Sliger, D 31. Date filed (Month, Day Year) JAN 0 5 2007

Suger, D.O

Smar 1-165 pital of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Res 600

Bultimore 2401 W. Belvedere Ave

29d. Date signed (Month, Day, Year)

State

29b. Signature and title of certifie

TIMOTHY LOW

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 5

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

OSLER DRIVE TOWSON,

29c. License number

D24034

29d. Date signed (Month, Day, Year)

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** 0724 WHITE 2007 STEPHANIE JAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMALITAN HOSPITAL NA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 4 1 M 2 F 212-58-4171 Yrs. NOV 13, 1952 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or items 23e or 28e-f show vent, the Medical Exeminer must be nutified as 1 √es 2 No Baltmore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21212 Coldspany Lane USA 407 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify African 1 ☐ Yes 2 No 21215-0036 Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Goodwill Industries Clerk 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 'is marked oth White Sr. Robert Ivene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If Item 27 is any Injury or other fram Robert White, 407 E. Coldspring Lune Jr. Brother Bulf. MP 2/2/2 20c. Location - City or Town, State Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/11/07 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. Balfmore MD 22. Name and Address of Earlity Service, P. A. Harry P. Close Funeral Service, P. A. 5126 Belance Road, Bultmore MD 2120 21. Signature of Funeral Service Licen Bultmore mo 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner RESISTANT ENTERDEDECHS LANCOMYCIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): signed by the attending physician I be detached tor use as the burial 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Dav 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown Part II. Other significent conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CARCINOMA WITH 1 Yes 2 No 3 Probably 4 Vnknown METASTASIS should s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No HYPERTE NSION 24a. Was an has autopsy performe 1 Yes 2 No Vital us after Atte..
urs after death.
eral Director: After this ceru...
by the funeral director, pr 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 JAN 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m RAVEN BLUD, BALTIMORE MD 21239 5601 WYEL HAKIM LOCH 31. Date filed (Month, Day, Year) 32 Registrar's Signature... State JAN 0 5 2007 Registrar

EPHANIE

State of Maryland / Department of Health and Mental Hygiene

00105

			1 - State Registrar			Cer	tificate of	Death	F	leg. No.	101	00103
F	Physici	an	1. Decedent's Name (First, Middle, Last	1)					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	_	FREDA					WHITE	JANUARY		007	11:00 P M
Ž	Examin	er	4a. Facility Name (If not institution, give		601		4b. City, Town, o		Death	4c. Count	y of Death	
			3021 FALLSTAFF 5. Social Security Number 6. Se			ast birthday)	BALTIM If Under 1 Year		Hrs. 8. Date of Birtl	1		N/A place (State or Foreign
	Funeral Director			_M 2 ∏ F	93	Yrs.	Months Days		08/07/13		Coul	
10	pue »		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loc	ation] 1	I 0d. Inside City Limits
	haryla r sho ed at	ŏ	MD N/	Δ	-	BALTIM						1 V Yes 2 □ No
	the A	Director	10e. Street and Number	, ,		D/(L II)	10f. Zip Code			10g. Citizen of	What Coul	ntry?
	death with the Maryland rms 23a or 28a-f show r must be notified at		3021 FALLSTAFF	ROAD APT.	601		21209	1		l	J.S.A	
	death	Funeral		12. Was Decedent E Armed Forces?		S. 13. V	Vas Decedent of H	lispanic Origin		14. Ra	ce - Americ	can Indian,
0000	be filed within 72 hours after death with the Marylan Ital Hygiene. It other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 ∏Yes 2 X N If Yes, Give Year or Dates:	lo		Yes 2 No	Specify:	rueno nican, etc.)	Speci	ack, White, ify:	WHITE
ဂ ဂ	72 ho 'natui lical	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	ent's Usual Occup kind of work done O NOT use retire	oation during most of	f working	16b. Kind of E	Business/In	dustry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		O NOT use retire	d)			OWN I	JOME
Z	illed v Hygie ther t nt, th		12 17. Father's Name (<i>First, Middle, Last</i>)			HUI	LMAKEK	18. Mother's	Name (First, Middle,	Maiden Surna		IONL
land	lid be fental rked o	To Be	ADOLPH			STATT	ER	ESTHE	•		,	GOLDSTEIN
a	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)	ype. Print)		19b. Mailin	g Address (Street	and Number o	or Rural Route Numbe	r, City or Town	n, State, Zip	Code)
χ. Σ	and sealth m 27			DAUGHTER	T			OAD -	<u>RANDALLSTO</u>			
0	Pages 1 nent of H nt: If iter iry or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State	CE	emetery, cren	sition (Name of natory or other pla		Date	20c. Location	-	
altimo	t. Page ntment o ntant: if njury or		4 □ Donation 5 □ Other (Specify,		ветн	JACOB				FINKSBU		
מ	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens Matter Countries				Name and Addre		SOL LEVI OWN ROAD -			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	-ival	vular	er the mode of dyin	ng, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
		Examiner	b. Due to (or as a consequence of): Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):									
08/00,	ertificate be ex ling physician a e as the burial.	ledical Ex		Due to (or as a	a consequ	ence or):						
×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome _I 1□Live birth 4□Pregnant at 9□Unknown	2 □ Fetal	death 3	Ectopic pregnanc Other (specify) _	у			ate of delivi	ery Day Year
ŗ.	that ined by detail		Part II. Other significant conditions co	ontributing to death bu	ıt not resu	lting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?
<u> </u>	quires in sign uld be	d by							1 Y	es 2 No	3 ☐ Prol	pably 4 □Unknown
Lec	2 38	Completed							24a. Was a autop perfor	sv	prior to co death?	opsy findings available impletion of cause of
VIII A	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?					26. Place of	1 Yes Death (Check only o		1 163	2010
0 0	G 5. ₹	Tof	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatien		4 LI Nursi	ing Home Resid	ence 6 □Ot	ther (Specia	fy)
	ing P After t iunera		27. Manner of Death 1/22 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Y Year)	28b. Time of Injury	28c. Inju		28d. Describe h	ow injury occu	rred	
UNISION	Attending r death. ector: Affer by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	ırv - At hoi	me farm stre		Yes 2 □ No		treet and Num	ber or Rur	al Route Number,
2	after Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	ioti rastory, silico		City or Tow	n, State)	ibo. Or riare	ar roate ramber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	/slcian: To the best of liner: On the basis of and manner sta	examinat	vledge, death ion and/or inv	occurred at the ti restigation, in my	ime, date and popinion, death	place, and due to the occurred at the time,	cause(s) and n	nanner as s e, and due t	stated. o the cause(s)
•	To the within To the Complete	Me	29b. Signature end title of certifie	Mor		N	29c. Licens	se number	364	29d. Date sign	ed (Month,	Day, Year)
•	10		30. Name and address of person who c	completed cause of de	eath (Item	23a) (Type, I	Print)	11-	A A . A	7:115	1	ı
	10		5 Park Cen	ter Ct) (DWI	05 Mi	115,1	VID a	2111	/	

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Marylan		artment rtificate			nd Me		giene Reg. Nø2	07	00106
	1. Decedent's Name (First, Middle, Last) Physician Gladys Shears Williams										2. Date of De	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution			MITI		own orla	ocation of	Death	1 3		tv of Death	12:45a. M
	Examin	er	Genesis Elde		51)			1time		Death			N/A	
	Funeral		5. Social Security Number			last birthday)	If Under 1	Year I	If Under 24	Hrs.	8. Date of Bir (Month, Da	th v Year)	9. Birthp	place (State or Foreign
Section 1	Director		212-42-0351	1□ M 2 X F	63	Yrs.	WOTTE	Days	nouis	IVIIII.	3 17	1943	I	MĎ
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	I0d. Inside City Limits
	Maryl: f sho ied at	ō		N/A	В	altimo	re							1 Yes 2 □ No
	28a-	rect	10e. Street and Number				10f. Zip (Code				10g. Citizen o	f What Cour	ntry?
	h with 23a or st be	a D	2321 Barcla	y Street				2121	.8			US	A	
	ems s	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U	.S. 13.	Was Decede	ent of Hisp fv Cuban.	anic Origin	n? (Spec	cify Yes or No Rican, etc.))- 14. R	ace - Americ	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Date	No No		1□Yes 2		Specify:		, ,	Spec		lack
Ö	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Meclical Examiner must be notified at	d be	15. Deceden	16a Dece	dent's Usual	Occupation	on			16b. Kind of				
15	in 72 n "na Meric	plet	(Specify only highes	st grade completed)		(Give	kind of work DO NOT use	done dur retired)	ring most o	of working	g	TOD: TAING OF	Du31/1033/111	dustry
21215-0036	filed within Hygiene. Her than "	Completed	Elementary/Secondary (0-12) 12th	College (1-4e N/A		Dis	abled					N/A	1	
pu	al Hy i othe	Be C	17. Father's Name (First, Middle,	,				18				, Maiden Surn		7h
Maryland	should be filed and Mental Hygi s marked other umatic event, ti	ဥ	Richard		itts					lbert		[hompso		Shears
Mar	au au		19a. Informant's Name/Relations Ben Williams—hu									er, City or Tow		Code)
	ges 1 and t of Health if item 27 or other t		20a. Method of Disposition	BDario	20b. F	2321 Place of Disponentery, crei	Barc]				nore, f	MD 21 20c. Location	218	own. State
Baltimore,	e = 5		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from Sta	ile				1	(0. (2)	007			
₩	permit. Pag Department Important: any injury o		21. Signature of Funeral Service		Ge	arrison	Name and			/9/2		Owing ERAL HO		
ä	Depa Impo any ir		1 Dlade	y wo	me	ر ا د~	101 E	. Nor	rth A			imore,		21202
	6		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the deat									Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition	Cie	e Co	PD	Cha	mi c	coh	arte	utino	Duly	OF)	Onset and Death
	/Medical Examiner		resulting in death)	Due to (ar	as a conseq	juence of):	I-	-		0		1	7	
	5	<u>.</u>	Sequentially list conditions,	t. Mous	as a conseq	16081	LY_	- 1						
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S Outli	A COURSE	2111 -	Lup,	the	lin.					
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or	as a conseg	uence of):	1 100	T CHAIL		-				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical		La Plu	nol	2/1	usu	750						
9	rtifica ng ph	Medi	IF FEMALE:	T T		- (0								
Box	death certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth]Ectopic pre	gnancy					ate of delivent	ery Day Year
	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	4□Pregnan 9□Unknow		leath 5	Other (spe	cify)					nonti	Day real
P.0	res that the de signed by the a be detached t		Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	nderlying ca	use given	in Part I.		23e. Did t	obacco use co	ntribute to t	ne cause of death?
Vital Records,	uires signe Id be	d by	Moulin	isws			, ,				10	Yes 2 No	3 ☐ Prot	pably 4 Onknown
8	w requir s been s should	Completed	DIFO. No.	to					-		24a. Was	an 24t	. Were auto	psy findings available
Re	The lay te has age 2	m o	Chippon	0							autoj perfo 1 Yes	psy prmed	prior to co death?	mpletion of cause of
ta	iclan: The certificate hare rector, page	Be C	25. Was case referred to nedical					2	26. Place 0	f Death	(Check only c	*	1 ☐ Yes	2 No
or V	S S T	ToE	examiner? 1 ☐ Yes 2 ☑ Yo	Hospital: 1 ☐ Inp.	atient 2	ER/Outpatier	t 3□ DO	Other:	4. Nurs	ing Hom	e 5□Resi	dence 6 □C	ther (Specif	y)
D C	ding Ph h. After thi funeral		27. Manner Death 1 Statural 5 ☐ Pendin	28a. Date of I (Month,	njury <i>Day Year)</i>	28b. Time of Injury		lc. Injury a Work?			8d. Describe	how injury occ	ırred	
Sic	Attending r death. ector: After by the funer	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be I ago Place of	injuny - At h	ome, farm, str	M		es 2∐No	-	Of Logation (Ctroot and Mus	abor or Burn	al Poute Number
Division	l or A after d Direc	Certification:	4 ☐ Homicide determ	building	etc. (Specif	fy)	eet, ractory,	Office		20	City or To	wn, State)	iber or mura	al Route Number,
	Hospital 4 hours a Funeral I		29a. Certifier 1 Certifyin	g Physician: To the be	est of my kno	wledge, deat	n occurred a	t the time,	, date and	place, ar	nd due to the	cause(s) and i	manner as s	tated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basi and manner	s of examina stated.	ation and/or in	vestigation,	in my opir	nion, death	occurre	d at the time,	date and place	e, and due to	o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifie	P nJ	/	MD	29c.	License n	umber	. 1 .		29d. Date sign	ed (Month,	Day, Year)
	.1		ristoer	Locker	4	1111		NH	101	17			1/2	007
	4		30. Name and address of person	who completed cause	death (Item	n 23a) (Type)	Print) > 1	26	200	11:0	10		1 1	
	Sta	to	31. Date filed (Month, Der, Year)	32. 199	istrar's Signa	≥µUU ature	25	2 1	70°U	me	M M	1)21	LO	•
	Sta Registr		JAN 0 4			le A	A TO						·	
			VAILV	CUUI LANGE	1 A CT		ACCUSED NO							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Marylai		artment of H rtificate of L		_	giene 0 0	7	00107
	Physic	ian	1. Decedent's Name (First, Middle,	Last)				W. 2	2. Date of De.		Vear	3. Time of Death
	Physic /Medi		Sandra Clai	re Walke	er				Januar		O7	5:45 A м
	Examir	ner	4a. Fecility Name (If not institution,				**	Location of Death		4c. County of		
			Joseph Rich 5. Social Security Number	ey Hospi		In at hirthday	Balti If Under 1 Year	MOTE If Under 24 Hrs.	0.0-4-1/0	N/A		
	Funeral Director		216-56-8102	1□M 2∑F	7. Age (In yrs	74 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da July 12	2, 1952	Count	ace (State or Foreign ry) 1 land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
	Many -1-sh	Ď	Maryland N/A			Bal	timore					1 XYes 2 No
	r 28e	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Count	ry?
	th with	a D	821 Rappolla St	reet			2122	4		US	Δ	
	- dea	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spanic Origin?	ecify Yes or No-	14. Race	- America	an Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other then "natural", or Items 23a or 28e-f ehow aumatic event, the Macical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2X No iive		Yes X No	Specify:	ribari, oto.,		Whit	
Š	2 hou	ed	15. Decedent's	Education		16a. Deced	ent's Usual Occupa	ition		16b. Kind of Bus		
21215-0036	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)) (1-4or 5+)	(Give	kind of work done d OO NOT use retired)	uring most of worki		700, 11110 01 040	nii oo a ii oo	u3.1.y
	ed wit	ပ်		5+		Psych:	iatric Nu	rse Thera	pist	Hospit	tal	
2	be file tal Hy doth event	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle,	Maiden Surname	1)	
<u>√</u>	ould Men Marke	ု	Hugh M. Walker						Cooper			
Maryland	d 2 should th and Men 7 ie marke traumatic	0.5	19a. Informant's Name/Relationship				g Address (Street a					Code)
	1 an 16al 18 E		Ralph Tucker, 1	Husband	20h I		appolla St		timore,			1224
Гог	Peges nent of I int: If its iry or of		1 Burial 2 Cremation 3		State	cemetery, cren	natory or other place	9)		20c. Location - C	,	
Baltimore,	교통합者 .		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice		Me		ematory In			Baltimo	ore,	Maryland
, &	Depa impo eny i		Thomas Gre	Duy-]	Name and Address Cremation 199 Freder	Society	Of Mary	land, Ir	IC	J 01000
4			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the dear	th. Do not ente	or the mode of ying	, such as cardia	or respiratory ar	rest,		Approximate
W	Physician		Immediate Cause (Final disease or condition	ly one cause	2011	Un	MHA	mots	+1)	hvale	,	Interval Between Onset and Death
H	/Medical		resulting in death)	aDue to	(or as 1 consec	quence f):	WILL	mer	100	LOVIN		
3	Examiner		Sacrentially list conditions	b							1	,
5./	sit 9d	iner	Saguentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):						
5	and I-tran	Examiner	that initiated events resulting in death) Last	c	(or as a consec	uonoo of\:						
709	cate be executed physicien and the burial-transit			, Due to	(0) 83 8 0011360	tuerice or).						
1 / 2	phy the	edicai		d								_552
X	nding use a	N N	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna					23d. Date	of deliver	v
₫	The law requires that the death certificate hes been signed by the attending to age 2 should be detached for use as	by Physician/Me	in the past 12 months?	4☐Pregi	birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)			Mont		y Day Year
€0.	at the by th tache	hys	9 Unknown	9□ Unkn								
3°,	signed be de	by	Part II. Other significant conditions	contributing to d	leath but not res	sulting in the un	derlying cause giver	n in Part I.	23e. Did to	bacco use contrib	oute to the	cause of de
Qo	v requir been si should	ted					-		1 🗆 Y	es 2 □ No 3	Probat	bly 4 7 nknown
ۋرىر	e faw hes b	Completed							24a. Was a	an 24b. We	ere autops	sy findings available pletion of cause of
¹ <u>π</u>									perfor	med? de 2 No 1 E	ath? Yes 2	!□ No
₹گے	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death	Check only or	10)		Harris
2,4	Phys rat dii	<u>د</u>	1 Yes 2 No 27. Manuar of Death	28a. Date		ER/Outpatient 28b. Time of		4 Li Iduising Hor				1032111
. Ø 5	Attending Pr r death. ector: After th by the funeral	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mon	nth, Day Year)	Injury	28c. Injury Work? M 1 7	es 2 No	ad. Describe n	ow injury occurred	1	/
Division	Atten r dea octor	fica	3 ☐ Suicide 6 ☐ Could not	be as pu	of Injury - At he	ome, farm, stre	et, factory, office		28f. Location (S	treet and Number	or Rural I	Route Number
ă	s afte	Certification;	4 Homicide	build	ing, etc." (Specif	(y)	,,		City or Town	n. State)		iooto ribindor.
	To the Hospital or Atlandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier Certifying I	hysician: To the	best of my kno	wledge, death	occurred at the time	, date and place, a	and due to the c	ause(s) and manr	ner as stat	ed.
	the H the F the F	Medical		and man	ner stated.	and/or inv	estigation, in my opi	nion, death occurre	d at the time, d	ate and place, an	d due to th	he cause(s)
	Son Son	2	29b. Signature and title of certifier	1	1110		29c. License	number	2	9d. Date signed (Month, Da	ay. Year)
			10 WW/M	MKL)	11/1		110	112		14/1	17	
	10		30. Name address of person	completed caus	se of death (Item	73a) (Type, F	rint)	PIB.	THE	4/2	17	10
	Sta	to	31. Date filed (Month, Day, Ygar)	11 7 7 B	Aniso r's Signa	iture	1041	4 10	110,1	16 4	1/6	
	Registra		JAN 0	4 2007	A CARLON AND AND AND AND AND AND AND AND AND AN	A. S.	Coastes		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Whee 2:42 A M abriell Variyar Q 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner medical Center tnapalis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F NA Yrs. Director 6 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28a-f show any Injury or other treumatic event, the Madical Examinat must be notified at once. 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 60 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 ☐ Widowed 4 ☐ Divorced ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kichard Dantes lari 2 Ca arpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Sage brush Severn arica spenter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State gate Memorial the January 05,07 le Rd. Annapolis Ad 4 ☐ Donation 5 ☐ Other (Specify) 21. Sometime of Funeral Service Licensee 22. Name and Address of Facility
Ancy m. Wallace Ancy m. BAHAMORE 3405 W. FRANKIN Street 21239 Enter the diseas or neart failure. Approximate Interval Between Onset and Death isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Extreme prema
Due to (or as a consequence of): /Medical **Examiner** spicato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2) No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after deau. **I Director: After 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral E Hospital 1xt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and address of person who completed c 31. Date filed (Month, Day, Year) 32. Re strar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Miriam Mary Wallace 6:15 P.M /Medical January 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Broadmead Retirement Community Hunt Valley Baltimore County 8. Date of Birth (Month, Day, Year) NOV • 19, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2XF Months Days Hours Min 85 1921 New York, N.Y. 088-12-1764 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked othar than "natural", or items 23a or 28a-f show traumatic evant, I'm Medical Examinar must be notified at 10d. Inside City Limits Baltimore County Director Hunt Valley 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married □Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2X No Specify: White ð 3 Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Hospital Social Worker 12 4 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Is markad ot Max Mandel Anna Nichtberger permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Matthew A. Wallace (Son) 600 Wallerson Road, Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State Evans Funeral Chapel * 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee/) 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road, Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coordibute to the cause of death? Completed by 1 ☐ Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vita 2 1 No 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 🗌 Yes 20No 4 Unursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending

Division of

Certification: 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Leroy Zinkhan State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Physician/ Medical Examiner Decedent's Name (First, Middle Last) 2. Date of Death Month Day January 2, 2007 2102 hrs Michael Leroy Zinkhan acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 602 Riley Court Apt. A Harford 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of **Funeral** Days Months Hours Min Director 10.25.1968 212.02.9889 1 >4 Country) Usual Residence of Decedent 10a State IOc. City, Town or Location 10d Inside City Limits or 28a-f show Harford MD Joppa 1 Yes 2 No after death with the Maryland Director 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country 21085 U.S.A. 602 Riley Court Apt. items 23a Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes White Yes, Give Year Yes 2 No specify. Widowed Divorced Specify is marked other than "natural", atic event, the Medical Examiner 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4 or 5+) 21215-0036 Fork Lift Operator Warehouse be filed within of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 195. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1978 matic event, Be Robert L Zinkhan 19a Informant's Name/Relationship (Type, Print) Ida Zinkhan/mother If item 27 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place Burial 2 Cremation 3 Removal from State Pages 1 Department of 01.05.07 Beltsville, MD Donation 5 Other Specify Chesapeake Crem. 5 Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation And Funeral Balto 8717 Green Pastures Dr. MD ternatives Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED X AMENDED #7, perFH. 23a,27,28a-f, perME, g863, 1/19/07 TT Division of Vital Records, P.O. Box 68760, phy the l 23d Date of delivery If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? page 2 performed? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other 4 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene After this 2 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work' subject found with cord wrapped Natural Yes 2 X No death Funeral Director: Fnd 1/2/2007 Fnd 9:02 nm around neck 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number. City 6 X Could not be 3 Suicide or Town, State) 602 Riley Court Apt A determined residence 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifig 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 3, 2007 who completed cause of death (Item 23a) 30 Name and address of person

State Registrar

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jan. 1, Frank V. Armetta, Sr. 2007 8:02 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8721 Roper Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 17, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1**X**M 2□ F 213-05-3582 88 Oct. 1918 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f shov notified at 1 ☐ Yes 2 X No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner. 8721 Roper Road 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Armetta 2 Mary Constatino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Frank V. Armetta, Jr./Son 964 Keepway loop Oviedo, Florida 32765 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 1/5/07 | Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mars /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the l attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□ No 2 No 25. Was case referred examiner? Be 26 Place of Death (Check only one) Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	larylar		artmer rtificat			and M		jiene	400	7 (001	12
	Physici	an	Decedent's Name (First, Middle, La	st)	-						2. Date of Dea Month				3. Time of D	Death
	/Medi	cal	Howard C. Ames 4a. Facility Name (If not institution, giv.	n street and sumber	1		4h O'h	T	1		January	1,	2007		2:30	A ^M
	Examir	ner	4205 Fordham Road		,			timo	Location o	r Death		4c. County of Death Baltimore				
	Funeral	Г	5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday)		1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth				e (State or	Foreign
	Director		216-01-9437 Usual Residence of Decedent	⊠ M 2□F	89	Yrs.	MOTUTE	Days	Hours	MIN.	8. Date of Birth (Month, Day 4/16/1	7	M	laryl	e (State or and	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d.	Inside City	Limits
	a-fer	ctor	Md Baltim	ore		Ва	1 ti mo	re							1 Tyes 2	Z M No
	or 28	Director	10e. Street and Number		-1		10f. Zip	Code			1	0g. Cit	izen of What	Country	?	
	s 23s	erai	4205 Fordham Roa		-			2122					USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other than "natural", or Itams 23e or 28e-f ehow eny Injury or other traumatic event, I'm Mudical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 S If Yes, Give Year or Dates:	?		Was Deced If Yes, sped 1 ☐ Yes		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto l	city Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	/hite, etc.		
ğ	2 hou	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usua	al Occupa	tion			16b. K	ind of Busine	Whit ess/Indust		
215	thin 7	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of wo DO NOT us	rk done di	uring most	of workir	ng			, o <u>a</u> 1110 g s 1	· · · y	
2	led wi		12	0		Cab	le Pa						tern E	Elect	ric	
and	d be find H	Be	17. Father's Name (First, Middle, Last) Frederick	С.	۸						(First, Middle, M	Maiden	ŕ			
	should nd Me mark imatic	၉	19a. Informant's Name/Relationship (1		All	19h Mailir	n Address	(Street a	Albe		M . I Route Number.	Cityo	Hoffs		de)	
S	alth ar 27 le 27 le		Mrs. Aira E. Ames	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		4205					imore,					
ĕ.	of Head		20a. Method of Disposition	5	20b. P	Place of Dispo	sition (Nan	ne of					cation - City			
Baltimore, Maryland 21215-0036	permit. Page Department (Important: If eny injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ➢ Other (聚內代	ombment		don Pa	rk Ce	mete	ry	1/3/	07	Ba1	timore	, Ma	rylan	ıd
gail	Depart Import eny in		21. Signature of Funeral Service Licen	S00	51.7	22					ıdon Par	k F	uneral	Hom	ne	
	40200	9 0	23a. Part1 Enter the disease, or comp	plications that saves	d the deat	- D					Baltimo		Mary		21229)
	Certificate be executed ding physician and unding physician and reas the purial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CARDO Due to (or as b. MALN Due to (or as c. Due to (or as	a consequence of the consequence	2 (T/O derice of).									erval Betwe	
õ ×	leath certifica attending ph	/Med	IF FEMALE:	220 16 1100 01100												
Ď	atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe					2	23d. Date of o Month	delivery Day	/ Yea	ar
λ, T	w requires thet the de been signed by the should be detached	by Pl	Part II. Other significant conditions co	entributing to death b	ut not resu	ulting in the un	derlying ca	use giver	in Part I.		23e. Did tob	acco u	se contribute	to the ca	ause of dea	th?
ecord	equire en sig ould b		ADENOCARCINON	A OF DE	2050	ATE					1 □ Ye	s 20	21√10 3 □	Probably	4 □Unk	known
L L	The lar	Completed								_	24a. Was ar autopsy perform 1 Yes 2	/	death	o comple	tion of caus	allable se of
VII	certifi	Be	25. Was case referred to medical examiner?	Hospital:						of Death	Check only one)				
5	Phys	2	1 ☐ Yes 2 ☐/No 27. Manner of Death	1 L Inpatie		ER/Outpatient 28b. Time of			4 🗀 14015		e 5 Aesidei			pecify)		
5	nding P th. :: After t	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da)	Year)	Injury	M	Bc. Injury a Work?	ıı əs 2.∐No		3d. Describe ho	w injury	occurred /			
DIVISION	ol or Atter after dea i Director d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. (Specify	me, farm, stre					3f. Location (Str. City or Town,	eet and State)	d Number or	Rural Roi	ute Numbe	τ,
:		Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of the said of the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred a estigation,	it the time in my opir	, date and nion, death	place, ar	nd due to the cal d at the time, da	use(s) te and	and manner place, and d	as stated ue to the	l. cause(s)	
1		Ž	29b. Signature and title of certifier	- 00	,			License r		,			signed (Mo		,	
	9		· Jaurence G	allager,	MD				178		J	AA	1.02,	20	07	
-	1 1		30. Name and address of person who c		eath (Item	23a) (Type, F	Print)	306	A1- 0	1.	R.	. تف و		nr :	200	0
g .	Stat	e_	31. Date filed (Month, Day, Year)	32. Horistra	ar's Signat	ure ///	uiaei	CK	UNC	rox	e xu	VIII	neit,	(H) C	7/00	8
	Registra		JAN 0 8 2	007	Alled a	A A	21/2/2									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Day 3 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** anuary 1813 2007 Blevins Rosemary Frances /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center

Social Security Number 6. Sex 7. Age (In yrs. last birthday) Bel Air
If Under 1 Year
Months Days Harford Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Min Hours 1 □ M 2 □XF 215-46-9161 61 7/28/1945 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r than "naturel", or Items 23s or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 503 Grigsby Court Α. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11, Marital Status within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Health Insurance Elementary/Secondary (0-12) Billing Clerk 12 Company other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental ပ္ Chester Wilant Rose Morell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4626 Silver Spring Road Perry Hall, Maryland Susanne Hopkins (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages permit. Pages Department of Important: If It eny injury or o to 1/8₇ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es nichail 23a. Part. Enter the disease, of combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner mmune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the attending | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes certificate 2 No 1 Yes Vital 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 (Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To to nours efter death.

nerel Director: After this
filled in by the funerel di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Division 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital o within 24 hours eff To the Funerel Di completely filled in 29a. Certifier 1 [Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. 500 Upper Kurtom

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 0

evins

32. Registrar's Signature

07-00042 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Billy Darrell Busch State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3 Time of Death Medical Examiner Billy Darrell Busch January 2, 2007 1045 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Greater Baltimore Medical Center Towson **Baltimore County** 5. Social Security Number **Funeral** 7 Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Director Months Days Hours Min Foreign 220-82-7615 1**XX**M 2 48 Country) Kentucky 10/31/1958 Usual Residence of Decedent iny 10c. City, Town or Location 10d Inside City Limits 28a-f show Maryland Harford Street at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2023 Mt. Horeb Road 21154 U.S.A. or items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Never Married 2 XXMarried Armed Forces White etc. Yes Widowed f Yes, Give Year Divorced Yes 2XX No specify "natural", Specify: White ş 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ner than " MD 21215-0036 d Mental Hygiene.
s marked other thatic event, the Medi Chemical Engineer Paper 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be William Garland Busch Chelsie Fouts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Ann Busch (Wife) 2023 Mt. Horeb Road, Street, Maryland 21154 Baltimore, N
permit Pages I and
Department of HealtI
Important: If item
injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place) Removal from State Oak Lawn Cemetery 01/08/07 Donation 5 Other Specify: Baltimore, Maryland 22 Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221
Approximate Interva Signature of 5 heral Service Licensee 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and a_Electrocution Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause Exami (215-29) or injury that in itemed events resulting in death) Last Due to (or as a consequence of) ca g physician a UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Month Day Pregnant at time of death Physici Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 24a. Was ar autopsy certificate

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours are.

To the Funeral Director:

Yes 2 ✔ No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Other₄ Inpatient 2 🗸 ER/Outpatient 3 1 🗸 Yes DOA Nursing Home 5 Residence 6 28a. Date of Injury FOUND: Day Year) 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural **FOUND** Subject was electrocuted Pending 1 **✓** Yes 2 Jan 2, 2007 0931 hrs 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 17701 Big Falls Road- Blue Mount Quarry, Monkton, MD determined (Specify) Quarry Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

mp

AN 0

29b Signature and title of certifier

31. Date filed (Month.

29c License number

O.C.M.E.

29d Date signed (Month, Day, Year) January 3, 2007

Yes 2 XXNo

Death

Year

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

Be

Certification:

Medical

this

After t

32. Registrar's Signature

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Jan 4, James Roy Butler 2007 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13, 1929 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 217 30 6802 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and it flem 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE"S MARYLAND 1 Yes 2 YNO Director UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2512 S.E. Crain Hywy 20774 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: African American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crew Chief WSSC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Butler Mary Proctor မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Butler (Wife) <u> 2512 S.E. Crain Hywy, Upper Marlboro, MD 20774</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 10, Date 2007 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, MD Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner vaavaplegiA Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ected attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 100 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0042040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ipper Marilboro 'ALOUX 20772 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month SELENA BROWN AN M 1353 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Mamland Medical Center If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F US45-58-2382 Usual Residence of Decedent Jan 17, 1965 newyork, NY Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Baltimore 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or USA 1204 W. Pratt Street 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural', or Iten dical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natu matic event, the Medical 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Nursina Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret ٩ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Pratt Sti Baltimure, Mb 21223 Romaine Smith 1204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bay New Crematory Jans, 2007 Dundals, MD 4 Donation 5 ☐ Other (Specify) Fred Huffen Street. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Methicillin Resistant Stan Aureus Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performe certificate ha 1 Yes 2 XNo 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ★Inpatient 2 □ ER/Outpatient 3 □ DOA Other: မှ 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled it 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blome Greene MD Domia Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2007 Registrar

DHMH 17 Rev 1/2001

		1 - State of Maryla		artment of I			ene g. N2 0 0 7	00118				
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death				
/Medi	cal	Allen V. Beauchamp 4a. Facility Name (If not institution, give street and number)		45 G3 T		January	4, 2007	4:20 P				
Exami	ner	Stella Maris		Timon	or Location of Death		4c. County of Death Baltimor					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		pplace (State or Foreig untry)				
Director		383-01-0376	Yrs.	Months Days	Hours Min.	Nov. 21,	1920 Mic	higan				
aryla •hov	2	MD Baltimore 10c. C	ity, Town or Lo					10d. Inside City Limits				
6 after death with the Marylan or Neme 23e or 28e-1 show christrat be notified at	Director	10e. Street and Number	Baldwi		·			1 ☐ Yes 2 🕅 No				
3a or	Ö	10 Carroll Meadows Drive		10f. Zip Code 210	110		g. Citizen of What Co					
death	Funerai	11. Marital Status 12. Was Decedent Ever in	J.S. 13.1		Hispanic Origin? (Sp an, Mexican, Puerto		Jnited Sta	ican Indian,				
ours after rel', or its	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	C.777 Y	f Yes, specify Cub 1 ☐ Yes 2 💢 No		Rican, etc.)	Black, White	hite				
Maryland 21215-UU36 nd 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other then "neturel", or iteme 23a or 28a-f show r traumatic event, the Medical Exarchine marke	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give		during most of work d)	ing 1	6b. Kind of Business/I					
filed with Hygiene. other ther	S	17. Father's Name (First, Middle, Last)	P	resident			Bayshore	Foods				
S d in S	Be	Allen V. Beauchamp, Sr.				e (First, Middle, M	aiden Surname)					
aryia should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b Mailin	n Address (Street	Inez Mc		er, City or Town, State, Zip Code)					
ire, Maryla s 1 and 2 should if Health and Men them 27 is marke other traumatic		Jeffrey J. Beauchamp, Son					vin, Maryla					
of Hear		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of natory or other place	ca)		Oc. Location - City or 1					
Saltimore, sernit. Pages 1 ar Department of Hea mportent: if Nem ny injury or othe						n.8,2007 T	imonium, M	arvland				
DallIMO permit. Pages Department of importent: if it any injury or o		21. Signature of Fundral Service Licensee MO1111		. Name and Addre			hisholm Fi					
		Monst	Se	rvices o	f Dulaney	Valley,	P.A. 200 I					
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
vate be executed shysicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause Disease or in fully that initiated events resulting in death) Last b. Due to (or as a conservation of the conserva										
res that the death certificate signed by the attending physis be detached for use as the	Physician/Medical	d	al death 3 🗆 death 5 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	Day Year				
equires the	þ	Part II. Other significant conditions contributing to death but not re-	sulting in the un	iderlying cause giv	en in Part I.	11	cco use contribute to					
w require been signature	etec					1 🗆 Yes	2⊠No 3□Pro	bably 4 □Unknown				
The iar ate has page 2	Completed					24a. Was an autopsy performe	death?	opsy findings available empletion of cause of 22 No				
Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	1500	3C DOA Oth	26. Place of Death							
g Phys er this eral dir	۳. ت	1 ☐ Yes 2 ☐ KNo	28b. Time of	28c. Injun Worl	4 K Nursing Hor	me 5 ☐ Resideno 28d. Describe how	e 6 □Other (Speci	(y)				
l or Attending I after death. Director: After I in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - 4t b	Injury ome, farm, stre	M 1 🗆	Yes 2 □No	28f. Location (Stre	et and Number or Run	al Route Number				
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only Madical Examiner: On the basis of examiner:	wledge death	occurred at the tim	ne date and place	City or Town,	State)					
the I hin 24 the F	Medical	and mainer stated.										
T with		29b. Signature and title of certifier Mesting Way N 30. Name and address of person who completed cause of death (Iter	MD	29c. License	274 0	J 6	Date signed (Month,	Day, Year)				
3117 Sta			DULAN1	Print) EY VALLEY	Y ROAD	TIMONIUM	MD 210	93				

4:20 P.M.

JANUARY 4, 2007

BEAUCHAMP, ALLEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7, perFh, 6863, 1/8/07 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Thomas Frank Brunetto 2,2007 10:05A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House - Montgomery Hospice Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 25, 1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F 139-16-5596 -85 84 New Jersev Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In the Mental "or items 23a or 28a-f show nit: if fear 27 is marked other than "hatural" or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 1√EYes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18128 Hayloft Drive 20855 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WWII Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Adjuster Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas P. Brunetto Rose Labetti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Brunetto, Son 18128 Hayloft Drive, Rockville, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.8,2007 Immaculate Conception Cem. Upper Montclair, NJ 21. Signature of Furteral Service Licensee 22. Name and Address of Facility Caggiano Funeral Home 62 Grove Street, Montclair, New Jersey 07042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis Syndrome Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Multiple Decubitus Ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Parkinson's Disease ending physician and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Ves 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√2 No 24a. Was an autopsy performed? 2 **X**No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Yes 2X No 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0058032 Telliamodo 1-2-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, MD MD 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) JAN 0 8 State Marias

DHMH 17 Rev 1/2001

Registrar

Grantes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #25, perMD, g863, 1/8/07 TT 1. Decedent's Name (First, Mjddle, Last) 2. Date of Death **Physician** Month Year Leloy January 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 165-18-3934 91 10/27/1915 PENNSYLVANIA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director MD CARROLL WESTMINSTER 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be 408 OAK HILL CT., APT A2 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: or items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 SHERIFF LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Mental CAMPBELL HARRY ELIZABETH JANE BURKETTE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5 2 5 5 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. LOIS C. YATES DAUGHTER 24200 N. ALMA SCHOOL RD., #33, SCOTTSDALE, AZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Donation 5 ☐ Other (Specify) EVERGREEN MEM.GARDENS 1/8/07 FINKSBURG, MD Funeral Service Licensee 22. Name and Address of Facility LETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** seul monas 6044 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Irac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed Be Certification: To

Division or Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed I Director: A within 24 hours a To the Funeral

													o coi	psy findings av mpletion of cau 2 No	
5. Was case referred to a examiner?	medical		26. Place of Death (Check only one)												
1 ☐ Yes 2 ☑ No		Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom							ome 5[ome 5 ☐ Residence 6 ☐ Other (Specify)					
2 Accident	Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М		Injury at Work? 1 ☐ Yes 2	2 □ No	28d. Describe how injury occurre □ No						
	Could not be determined	28e.	Place of injury - At he building, etc. (Special		t, facto	ory, of	fice		28f. Loc City	ation (S or Tow	Street and vn, State)	Number or	Rura	al Route Numbe	9 <i>r</i> ,
9a. Certifier 1 ☐ C (Check only 2 ☐ M one)	ertifying Phy ledical Exam	iner: On	To the best of my known the basis of examination of manner stated.	owledge, death o ation and/or inve	ccurre	ed at tho	he time, dat my opinion,	e and place death occu	, and due rred at the	to the	cause(s) date and	and manner place, and d	as st	tated. the cause(s)	

State

Medical

29c. License number

30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print

1645

31. Date filed (Month, Day, Year) **JAN 0 8**

29b. Signature and the of certifier

Registrar's Signature

		State of Maryland / De State of Maryland / De	partment of Health and ertificate of Death		giene	7 0012
Physicia	n	1. Decedent's Name (First, Middle, Last) Robert E. Childers		2. Date of De Month	eath Day Yea	
/Medic Examine	al	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM	4b. City, Town, or Location of Dea	JANUAR	4c. County of D	eath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $117 38 3128$ 117 M $2 \square F$ 66 Yrs.	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		y, Year)	Birthplace (State or Foreig Country) est Virginia
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State				10d. Inside City Limit:
or 28a-	Direc	10e. Street and Number	10f. Zip Code		10g. Citizen of What	
urs a	by Funeral Director	7928 Blue Anchor Court 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes. Give Year or Dates: Viet Name	21122 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No irto Rican, etc.)	U.S.A. 14. Race - A Black, W Specify: W	merican Indian, /hite, etc.
d within 72 ho giene. er than "naturi , the Medical i	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of w . DO NOT use retired) ineer		16b. Kind of Busine	
uld be file Mental Hy arked oth atic avent		17. Father's Name (First, Middle, Last) (Unknown)	Verd	a M. Chi		
and 2 sho salth and I n 27 is me er traume		Katherine Zebron / Niece 7928	Blue Anchor Cour	t Pasad	ena, Maryl	and 21122
Pages 1 nent of He ant: If Iten ury or oth		1 Rural 2 Cremation 3 Removal from State cemetery, o	position (Name of rematory or other place) te Veteran Cem. 01	Date /08/2007	20c. Location - City Crownsvil	
permit. Depertr Importa			001 Ritchie Highw	ay Balt		ce, P.A. yland 21225
ate be nysicie he bur	ilcal Examiner	23a. P. 1. Enter the disease or complications that caused the death. Do not shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY Due to (or as a consequence of): CHRONIC OBSTRUCT Due to (or as a consequence of): c				UNKNOWN UNKNOWN
ath certific attending por or use as	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of Month	delivery Day Year
uires that the de	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			e to the cause of death? Probably 4 Minknow
	Completed			24a. Was auto perfo 1 \(\text{Yes}	psy prior death	e autopsy findings available to completion of cause of h? Yes 2 \(\text{No} \)
- 02	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor	eath (Check only only only only only only only only	one) idence 6 🗆 Other (5	Specify)
Afte tune	Certification; T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury (Month, Day Year) 28b. Place of Injury - At home, farm,	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe	how injury occurred Street and Number of	r Rural Route Number,
To the Hospital or Attendity within 24 hours effer dealt To the Funeral Director: completely filled in by the		29a. Certifier 1 \(\mathbb{Z}\) Certifying Physician: To the best of my knowledge, do			cause(s) and manne	
o the Ho vithin 24 h o the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	investigation, in my opinion, death oc 29c. License number	curred at the time,	date and place, and 29d. Date signed (M	
P 5 P 0		· May.	D52739		JANUARY C	2007
0117		30. Name and address of person who completed cause of death (Item 23a) (Type SURESH SHANDELYA, M.D., VA MARYLANI		EM, PERR	Y POINT, M	ID. 21902
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	nack)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY Pay 3. Physician 2007 07:05AM lena /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Medical Center Baltimore Towson 8. Date of Birth (Month, Day,) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 ☐ M 2 XF 218-64-1635 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1 Karyes 2 □ No MY Director altimore 10g. Citizen of What Country? Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1□Yes 2XNo Specify: altimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, BO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "
Injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Suran 18. Nother's Name (First, Middle, Maiden Surname) Middle, Last Be 19a. Informant's Name/Relationship (Tybe... 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zio Code) 20a. Method of Disposition

1 Burial 2 Cremation 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 3 ☐Removal from State Department of Important: If any Injury or once, 01-09-07 Baltimore 4 □ Donation 5 □ Other (Specify) service ? 21. Signal re of Funeral Service Licensee ND 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 1 🔲 Inpatient ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours a er death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JAN 0 8 2007

KHOSROW TABASSI,

31. Date filed (Month, Day, Year)

Registrar's Signature

7601

M. D.

OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene") Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month Year **Physician** EVANS : 50 PM 2007 -ONIA A-NUAR-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baetrmore grong atonsville >umm() Nursens 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🗷 F 216-22-Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐Yes 2 ☐ No "natural", or items 23a or 28a-f st dical Examiner must be notified Director md. 10f. Zip Code 10g. Citizen of What Country's 10e. Street and Number Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes **(No** Black Baltimore, Maryland 21215-0036 Specify: Completed by Specify: 3 Widowed 4 □ Divorced t other than "nature event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 meste ioth NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Lebecca P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other trau Son Albert J. 811 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Leinsdowne Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundral Service Licensee 22. Name and Address of Facility Funeral + Bacto. rary larce 23a. Part1. F shock, If the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMONTA WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 Who Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Certification: After ↑ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 10061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Year)

JAN 0 8 2007

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7,8, perFH, 563, 1/8/07 II Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9.16 Edemberg 200 erald ANVAVY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde 1941 9. Birthplace (State Baltimore Washington redical Center
5 Social Security Number 6 Sex 7 Age 1/10 yes lest hinted av Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 M 2 □ F 65 -67339-34-3592 IL Director Usual Residence of Decedent deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla nen of Health and Mantal Hyglene.
and of Health and Mantal Hyglene.
and it if item 27 is marked other then "natural", or items 23s or 28s-1 show ury or other traumatic event, its Macical Examination and be notified in 1 ☐ Yes 2 🕅 No Director ANNE ARUNDEL ODENTON 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 630 CHAPELGATE DRIVE 21113 Funerai 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 Xi Yes 2 □ No VIETNAM If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **OCEANOGRAPHER** OCEANOGRAPHY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HASSEN **EIDENBERG** MINNIE SIDNEY ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 CHAPELGATE DRIVE - ODENTON, MD 21113 SUSAN EIDENBERG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if eny injury or once. VETERANS CEMETERY 01/05/2007 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final netic Failuis **Physician** h ours /Medical resulting in death) Due to (or as a consequence of): Examiner Cholangio carcin ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ed by the attending physicien and deteched for use as the burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnanl at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 1 1 1 1 1 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed 1 Yes 2 No NA certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Unatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and tile of certifier 29c. License number 29d, Date signed (Month, Day, Year) 100224B MO ed cause of death (Item 23a) (Type, Print) 30. Name and address of pe buentel 8 Olen Burnie, MB my 305 buchs 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2007 JOHN FANGIKIS JANUARY 7:30 A.™ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign XXM 2 F Days Hours 232-20 3488 78 PENNSYLVANIA 01-30-1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits BALTIMORE TIMONIUM 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BANDON COURT # 203 21093 S. U. 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XXX es 2 □ No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married XX Married 1 ☐ Yes XXNo Specify. WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DOUBLE "T" DINERS College (1-4or 5+) YEAR Elementary/Secondary (0-12) RESTAURANTEUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **FOTIOS** FANGIKIS DESPINA DEMETMADES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 BANDON COURT, # 203, TIMONIUM, MARYLAND, 21093 (DAUGHTER) FANGIKIS 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State CUB HILL, MARYLAND ST.DEMETRIOS CH.CEM. 01-06-2007 22. Name and Address of Facility 1050 YORK ROAD (R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 Approximate Interval Between Onset and Death schemic Due to (or as a consequence of): Dus to (or as a runsequence of)

Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 Ith and Mental F 27 is marked of traumatic ever Health a DEBRA item 27 other t 20a. Method of Disposition Department of H Important: If iter any Injury or oth XIX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Soryice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and is the burial-transit Exami Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectonic pregnancy ed by the a detached f Medical Certification: To Be Completed by

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ours after death.
neral Director: A
filled in by the fu Fo the Hospital within 24 hours a To the Funeral

Physician

/Medical

Examiner

10a. State

MD.

Funeral

Director

items 23a or 28a-f show ner must be notifled at

Hygiene. other than "natural", or i ent, the Medical Examir

Director

Funeral

þ

Completed

Be

the Maryland

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 Other (Month Day Year							
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown							
				24a. Was an autopsy performed 1 Yes 2								
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 [☐ER/Outpatient 3☐[Home 5 ☐ Residence	6 Mother (Specify) WOSDIVE								
27. Manner of D ath 1 Natural 5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	Bd. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not 6 ☐		nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)							
	hysician: To the best of my kn miner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)							
20h Signature and title of certifier		2	9c. License number	204	Date signed (Month Day Veer)							

State

W()6701 N

31. Date filed (Month, Day, Year)

82. Registrar's Signature JAN 0 8 2007

			Plea	se Type or P							_		
			1 - For State Registrar	State of I	waryian		artment of H rtificate of L		nd Mental Hy	/giene Reg. No	000	7 0010) (
	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month	eath Da	Year	3. Time of Death	- 0
	/Medic	cal	MILDRED 4a. Facility Name (If not institution	n, give street and numb	er)		T				2007 c. County of Dea	9:30 A	М
<i>3</i> ":	LXaiiiii	805 RESERVE CHAMPION DRIVE #204 ROCKVILLE MONTG									NTGOMER	Υ	
	Funeral Director	1 100 00 FCOC 1 M 2 M F 00 V Workins Days Hours Min. Algorith Pays (Park								9. Bi	rthplace (State or Fore country)	ign	
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Lim	nits
:	a-f sho	ctor	MD MOI	NTGOMERY		ROC	CKVILLE					1 X Yes 2 □	
:	with the	Director	10e. Street and Number 805 RESERVE	CHAMDION DD	TVF #2	20/1	10f. Zip Code		20850	10g. Ci	tizen of What C	ountry? USA	
	ems 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.		Was Decedent of Hi		20000 n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Am	erican Indian,	
9000	De flied within 72 hours after death with the maryland tall Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	14 V O'		Į.	1 □ Yes 2 No	Specify:	outo mean, etc.)		Black, Wh	WHITE	
2	"natur edical	leted	(Specify only highe	it's Education est grade completed)		i (Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most o	f working	16b. H	Kind of Busines	s/Industry	
717	ed within rgiene. er than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		MAKER			0	WN HOME		
and	or be file	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide							n Surname)	BERMAN		
	id z snould by th and Mente ?7 is marked traumatic ev	2	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a	and Number	or Rural Route Num			Zip Code)	
ou .	Heal Heal		PENNY GROSS A	/ DAUGHTER	20b. P	lace of Dispo	sition (Name of		N DRIVE #		ROCKVI	LLE, MD 20	850
			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate NEW	-	natorý or other plac FIORE CEI		/07/2007	ĺ	RMINGDA		
Dall	permit. Page Department of Important: If any Injury or once.		21. Signature of Europea Service	icensee		22	2. Name and Addres					S., INC.	
			23a. Part1. Exert le di ease, oi shock, in hear filiure. List	r complications that cau	sed the death	n. Do not ent					KESVILL	E, MD 2120 Approximate Interval Between	8
) F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	LY	мрнома						Onset and Death 3 MONTHS	
f E	Examiner			Due to (or	as a consequ	uence of):							
W	nsit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or	as a consequ	uence of):						-	
	e executed an and irial-transit	_	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):							
0/00	certificate be iding physicia ise as the bu	dical		d									
×	in certifi ending r use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna h 2 □ Feta		Ectopic pregnancy	,			23d. Date of de	elivery	
	the death the atten ched for u	Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nt at time of d		Other (specify)	-			Month	Day Year	
7	w requires mar me deam cermicate be ex been signed by the attending physician should be detached for use as the buria	by	Part II. Other significant conditi	ons contributing to deat	th but not resu	ulting in the u	nderlying cause give	en in Part I.				to the cause of death?	
ecords,	as been 2 should	oleted							24a. Wa			autopsy findings availa	
ׅׅ֡֞֝֞֜֞֜֝֞֝֜֝֜֝֡֝֝֜֝֡֡֝֝֜֡֡֝	sician: The law certificate has b irector, page 2 s	Completed							— aut per 1∐ Yes	opsy formed? 2 A N	prior to	completion of cause of	of
\II	r this certificanal	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 🛣 No	Hospital:	patient 2	EB/Outnatien	ot 3 DOA Othe	OF:	f Death <i>(Check only</i> ing Home 5 🛣 Res		C □0# += /0=	Este a	
_	e te no	on: T	27. Manner of Death 1 X Natural 5 □ Pendir	28a. Date of		28b. Time of Injury	f 28c. Injur Work	y at k?	28d. Describe			ecity)	
VISION	or Attending after death. Director: After in by the fune	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ		finjury - At ho	ome, farm, str	M 1 □	Yes 2 □ No	28f. Location	(Street a	nd Number or F	Rural Route Number,	
ַ בֿ	urs afte		4 [] Hornidae							own, Stat	·		
	of the hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edical	29a. Certifier 1 XX Certifyii (Check only 2 Medical	ng Physician: To the be Examiner: On the bas and manne	is of examina	wledge, deati tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the control occurred at the time	e cause(s e, date ar	s) and manner and place, and di	as stated. ue to the cause(s)	
	withii To th	M	29b. Signature and title of certifie	er Q1	0		29c. License			29d. Da	ate signed (Mor		
	0		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type.	Print)	D4588	30		JANUARY	5, 2007	
	J		LEON C. HWANG	i, M.D.	1396 P	ICCARD	DRIVE	ROCKVI	ILLE, MD 2	20850)		
	Sta Registr			8 2007	istrar's Signa	15 19	0344						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

			Certificate of Death	Reg. No.
				ete of Deeth onth Day Year
	Physici /Medio			MUALY 1 2007750 PM
	Examir		4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location	
			GENESIS HAMILTON CONTON. BARTIM. 5 Social Security Number 6 Sex 7 And In yes last high day 1 If Under 1 Year If Under 24 Hrs. 18 D.	
į,	Funeral Director		5. Social Security Number 216-07-7398 6. Sex 1 Months Days Hours Min. Super Security Number 92 Yrs. Set birthday 92 Yrs. 1 Months Days Hours Min. Apt	9. Birthplace (State or Foreign Country) 71 25, 1914 Maryland
	tend		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary Fe sh	ģ	Maryland N/A Baltimore	1 💢 Yes 2 🗆 No
	r 28s	ie	10e. Street end Number 10f. Zip Code	10g. Citizen of Whet Country?
	23a c	aiD	6040 Harford Road 21214	U.S.A.
	aep E E	ne	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	(es or No- 14. Race - American Indian, etc.) Black, White, etc.
Maryland 21215-0036	should be filed within 72 hours effer death with the Marylend and Mental Hygiene. The Hygiene. The Hygiene 23a or 28a-f show maric event, the Medical Examiner must be notified at	Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Yeer or Detes:	Specify: White
S O	72 h	etec	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
7	vithin ne.	m	Elementary/Secondary (0-12) College (1-4or 5+)	Our Home
2	Hygie Ther I	ပိ	12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First	Own Home
an	₩ E P S	å		Not Available
<u> </u>	should nd Mer marke umaric	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Rou	
	C/ G = 9	- 1	Thomas L. Getz Son 12 Ratna Court Baltimore	e, Maryland 21236
ē,	S 1 a other		20a. Method of Disposition 20b. Place of Disposition (Name of Cametery, crematory or other place)	te 20c. Location - City or Town, State
Ĕ	Peges nent of int; if its iry or o		1 Burial 2 Ci Cremation 3 Removal from State 4 Ponation 5 Other (Specify) Hilltop Service Corp.	Towson, Maryland
Baltimore,	parmit. Peges 1 and 2 should Dapartment of Haalth and Mer Important; If Itam 27 ie marke any injury or other traumatic once.	- 1		C Towson Funeral Home, Inc.
m	20 E 2 2			son, Maryland 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively, or heart failure. List only one dause on each line.	piratory arrest, Approximate Interval Between
	Physician			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. PROUMD (A) Due to (or as a consequence of):	
		ē	Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate	<i>Q.</i> .
	uted ansit	edicai Examiner	b. CHRONIC OBSTRUCTIVE	MULMON ANY
ó	exection and and and and and and and and and an	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): c	DISTAGE
68760,	ifficate be executed g physicien end as the buriel-transit	Cai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):	
89				
P.O. Box	ath ce trendi	lan/	d	
0	the a	/slc		23b. Did tobacco use contribute to the cause of death?
	The law raquiras that the death cer ata has been signed by the attendir page 2 should be detached for use	by Physician/N	END STAGE DEMENTIA (ALZHEIMER'S DISEASO)	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Division of Vital Records,	signe signe	d b	DISTASO)	4a. Was an autopsy 24b. Were autopsy findings
Ö	v raqu been shou	Completed		performed? available prior to completion of cause of death?
e e	has thas ige 2	Ĕ		1 Yes 2 Yes 1 Yes 2 No
<u>e</u>	ificate or, pe	BeC	25. Was case referred to medical 26. Place of Death (Che	
\(\)	s carl diract	To B	examiner? Hospitel:	5 ☐ Residence 6 ☐ Other (Specify)
ō	g Phy arthi	اڇ	27. Menny of Deeth 28a. Date of Injury 28b. Time of 28c. Injury et 28d. I	Describe how injury occurred
Ö	ath. or: Aft	atio	2 Accident investigation M 1 Yes 2 No	
Ž	r Atte	Certification:		ocation (Street and Number or Rural Route Number, ity or Town, State)
Ω	rai Dilled i	3		
	Hosp 24 ho Fune Fune	edicai	29a. Certifier (Check only one) 29a (Certifyi: g Physician: To the best of my knowledge, deeth occurred at the time, date end place, and discovered at an open control of examination end/or investigation, in my opinion, death occurred at and manner steted	ue to the ceuse(s) and manner as stated. the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funeral Director: After this cartificata has completely filled in by the funeral director, page 2	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	- s + ō		ATTENDING DOC 2235	JANUAKY 2 2007
,	1	-	30. Neme and eddress of pen or who completed cause of deeth (Item 23e) (Type, Print) MAN, NPINC (TA, GC
1)		30. Name and eddress of perior who completed cause of deeth (Item 23e) (Type, Print) May NPING (HAMILTON GENESIS CENTER, 6040, HAR	FORD RA MADIALY
	Sta		31. Dete filed (Month, Day, Year) 82. Registrer's Signeture	
	Registr	ar	IAN 0 8 2007 Marker A. A. A. A. A. A. A. A. A. A. A. A. A.	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2, 2007 11:45 AM January LENWARD HAMLETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, 6/25/33) Birthplace (State or Foreign Country) VA 7. Age (In yrs. last birthday Social Security Number **Funeral** Year) Months 1**X** M 2□ F 231-36-1313 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show a or 28a-f show t be notified at Yes 2 No P.G. Forest Heights MD Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 USA Pages 1 and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must be 5604 Shawnee Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metro Transit Landscaper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie B. Brandon Willie Hamlett ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWN STATES Private Forest Heights. MD 20745 19a. Informant's Name/Relationship (Type. Print) 5604 Shawnee Drive, Forest Heights, MD Vernell B. Hamlett/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chestnut Grove Cemetery 1/07/07 Semora, N. C. 22. Name and Address of Facility Frazier's Funeral Rome, Inc. 21. Sign A re of Funeral Service Liver es permit. 389 Rhode Island Avenue, N. W., Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Detail death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 TER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 D Natural 2 ☐ Accident 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year, Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 70 0

DHMH 17 Rev 1/2001

State Registrar 7010 branc

446

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDJACE

31. Date filed (Month, Day, Year,

JAN 0 8

07-00040 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Julieanna C. Heyn State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Decedent's Name (First, Middle,Last) Physician/ Date of Death Month Day January 1, 2007 Medical Examiner Julieanna C. Heyn 1409 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) **Funeral** Birthplace (State or Months Davs Hours Director 215-98-5452 06/20/1981 M 2 X F 25 Country) Usual Residence of Decedent 10b. County Oc. City Town or Location 10d Inside City Limits or 28a-f show 1 X Yes 2 No MD N/A Baltimore nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 3674 Falls Road 21211 U.S.A. items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 0 Yes Yes, Give Year Divorced Yes 2 X No specify: White Specify: "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) marked other than ' Baltimore, MD 21215-0036 Food Service Δâ Waitress Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Donald L. Heyn Darlene G. Rebhan 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is Darlene G. Heyn, Mother 3100 Falls Road, Baltimore, MD 21211 item . 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Ξ ment o Hilltop Service Corp. 01/06/2007 Towson, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Spandrias Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure List only one cause on each line Between Onset and /Medical Death Methadone intoxication with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED #23a,27,28a-f, perME, g863,1/19/07 TT Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 V Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital 1 / Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 1 V Yes After 1 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification; Natural within 24 hours after death Fo the Finneral Director: Pending Yes 2**y** No Fnd 12/24/2006 unk Investigation Accident 28f Location (Street and Number or Rural Route Number. City or Town, State) 3100 Falls Road Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined found in house (Specify) Baltimore, Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

29d. Date signed (Month, Day Year)

January 3, 2007

State Registrar

29b. Signature and title of certifier

person who completed cause of death (Item 23a) Deputy Chief Medical Examiner

30 Name and address of

Jack Titus MD!

31. Date filed (Month, Day, Year)

JAN 0 8 200

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year JANUARY 08:30AM Rita Marv Harris 4,2007 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 4,1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. Hours 1 ☐ M 2 ☑ F Maryland 220-14-9283 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 4807 Sunbrook Avenue U.S.A. 21206 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify. Specify: 3√ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John S. Waldhauser Roubal Antonia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Patty Price Baltimore, Maryland 21206 4807 Sunbrook Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □Removal from State Gardens of Faith Cem. 1/6/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses a Ita 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it is a leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2[**N**0 1 Tes 3 Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ဂ္ဂ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>

the death certificate be executed the burial-tran as use been signed by the s should be detached

P.O. Box 68760,

Division or Vital Records,

this certificate or Attending Physician: director After th funeral death. within 24 hours after death To the Funeral Director: ocmpletely filled in by the f

				performed? 1 Yes 2 No	death? 1 ☐ Yes 2 No							
25. Was case referred to medical		26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 E	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other										
27. Manner of Leath 1 Natural 5 □ Pending 2 □ Accident investigati	(Month, Day Year)	28b. Time of Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 Suicide 6 Could not determine		me, farm, street, factory,	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	Physician: To the best of my know											

29c. License number

DØØ17695

29d. Date signed (Month, Day, Year)

2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDAL LAH. J. HELOU M. D. 7601 OSLER DRIVE TOWSON, MARYLAND

31. Date filed (Month. Dav. Year) State JAN 0 8 Registrar

29b. Signature and title of certifier

one

32/Registrar's Signature 2005.6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

Matthews.

JAN 0 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Time of Deat

9. Birthplace (State or Foreign Country)
PA

White

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

9:00am M

2007

USA

Month

Specify:

Black, White, etc.

Carroll

DHMH 17 Rev 1/2001

20

State

Registrar

3125 Baltimore Blvd. Finksburg, MD 21048

07-00064 Calvin Henderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Parviir Fierraerse		1- For State Registrar State of Maryland / Department of Health and Menta Certificate of Death	Rec	g. No. 200	7 0013
Physicia Medical Exami	an/ ner	Decedent's Name (First, Middle,Last) CALVIN HENDERSON	2. Date of Death Month January 3,	Day Year	'3 Time of Death 0551 hrs
		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital 4b. City, Town, or Location of E Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 17 Age (In yrs. last birthday) If Under 1 Year If Under 2 Age (In yrs. last birthday) And Age (In yrs. last birthday) If Under 1 Year If Under 2 Age (In yrs. last birthday) And Age (In yrs. last birthday) If Under 1 Year If Under 2 Age (In yrs. last birthday) Age (In yrs. last	Min APR. 2	, 1960 Foreig	
'any	ŀ	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location			10d Inside City Limits
Aaryland 28a-f show 1 at once,	ţ	MD N/A BALTIMORE 10e, Street and Number	Lao	g. Citizen of What Cou	1X Yes 2 No
ith the Mar 23a or 28a notified at	Il Director	1701 CHILTON ST. 21218		USA	ntry ?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 1 Yes, Specify Cuban, Mexican, Performance of the Specif		aACK	
hours aff	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin during most of working life, DO NOT us		Specify: BL 16b. Kind of Business/	
£1 12	Completed	College (1-4 or 5+) 11TH FORKLIFT OPERATO	R		PACKING
21215-0036 Muld be filed within 7 Mental Hygiene marked other than c event, the Medica	a	LEROY HENDERSON, SR. LOUV		HENDERSON	
MD 2 nd 2 should alth and M m 27 is m	-	19a Informant's Name/Relationship (Type, Print) LOUVIONETTA HENDERSON/mother P.O.BOX244 TO			
4, 4 5 5 7		20a Method of Disposition 1	Date AN . 10 , 20	20c. Location - City or HENDER	Town, State
Baltimore permit Pages I Department of I Important: If	1	4 Ponation 5 Other Specify: OF CHRIST J 21. So lature of Funeral Service Licensee CALVIN B. SCRU	GGS FUNE	RAL HOME	
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line			21213 Approximate Interval Between Onset and
/Medical Examiner	i	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease Due to (or as a consequence of):			Death
1		Sequentially list conditions, b			
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated			
ecuted and transit		d d			
760, icate be exc physician the burial -	Medical	IF FEMALE AMENDED #23a,PII,27,28a-f, perME, g863, 1/ 23c. If yes, outcome of pregnancy	′29/07 TT	Toolour	
Ox 6876 eath certificat attending phy for use as the	sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pr	regnancy	23d Date of delivery	/ Day Y ear
Box 68 e death certifi the attending red for use as	Physic	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.	اھ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Morphine intoxication		pacco use contribute to	
rds, require been signould b	leted		24a. Wa s a autops		topsy findings available completion of cause of
Reco The law icate has	Completed		perform 1 V Yes 2	ned? death?	
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner? 26 Place of Death (Cherry 1		Residence 6 Other	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the starter death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be deteated.	on: To	27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d Describe ho	ow injury occurred	<u>*</u>
iSior Attend er death rector:	icatic	Accident Pending Fnd 1/3/2007 Fnd 5:20 am 1 Yes 2 X No		treet and Number or Ri.	ral Route-Number City
Divis Spital or At cours after d reral Direct filled in by	Certification:	4 Homicide determined (Specify) found at home	or Town, Sta Baltimore	ate) 1701 Chi , MD	rel Route Number City Lton Street
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated			
	Σ	29b Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo. January 4, 2007	nth, Day, Year)
L. L.		30 Name and address of person who completed cause of death (Item 23a)		, . ,	
1 1	ate	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	more, MD 21201		
Regis	trar	31. Date filed (Month, Day Year) 32. Registrar's Signature		·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year JENKINS 8:22 PM DIANNE TANUARY 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPIT AL BALTIMORE HOPKINS CITY JOHNS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X Days Hours 216-58-4450 MA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Nindsor MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3531 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
(life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) lam:ner att 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Adules (Street and Number or Rufal, Route Number, City or Town, State, Zip Code) 31 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) oud 21. Signature of Juneral Service Licenz une ral services Kandallstown, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE HEART 3 MUNTHS CONGESTIVE Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at

and Mental h

t of Health if item 27 i

permit. Page Depertment of Importent: if any injury or once.

death

within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

10a State

Director

Completed by Funeral

Be

2

Examine anding physician and use as the burial-transit Physician/Medical attending | been signed by the s should be detached t Completed by s certificate has t lirector, page 2 s Be this After this funeral of Certification: illed in by the fu

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

death.

To the Hospital o within 24 hours aff To the Funerel Di

0

I t	b. BREAST CANCER		no Hears
{ ,	Due to (or as a consequence of): c. CHRONIC KIDNEY DISEASE Due to (or as a consequence of):		5 YEARS
,	d		
2	23c. If yes, outcome of pregnancy 1	23d. Date of de Month	livery Day Year
ons cor	ntributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to 1 ☐ Yes 2 ☑ No 3 ☐ Po	o the cause of death?
		autopsy prior to performed? death?	utopsy findings available completion of cause of
	26. Place of Death Check	coniy one	
H	Hospital: 1' Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Spe	icify)
ig gation		scribe how injury occurred	

RES - 000

600

JANUARY 3, 2007

MD

NORTH WOLFE STREET, BALTIMORE

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 9 Unknowń Part II. Other significant conditi 25. Was case referred to medica examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death 1 Natural 2 Accident 5 Pendir 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) 2007

OLCAY AKSOY, MEDICAL DOLTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKSOY, THE TUHNS 32. Raistrar's Signature

HOPKINS HOSPITAL,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Jones Physician 42007

3. Time of Death

Itimor

Blac

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2□No

3 Probably

1 Yes

4 Unknown

1 8s 2 No

January /Medical County of Death 4b. City, Town, or Location of Death 4c 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Year If Under 24 Hrs. Hospital Center osse **Funeral** Year Days Min 78 1 □ M 2 X F Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 28a-f ahow the Medical Examiner must be notified at Baetin NIA Funeral Director ma 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian is marked other than "neturel", or items 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drivate College (1-4or 5+) Elementary/Secondary (0-12) medical Doctor 95515lani permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other 11 any injury or other treumatic avent, IIIs once. 12th NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (roodwin Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER Pun IAB Delto, ma, elda 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9-0 carnel Cemi 4 □Donation 5 □Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility edition Dallo, ma Franch F. It. 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure. List only one cause on each line. Immediate Caus (Final disease or condition resulting in deat) Cerebrovasc **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hypercholesterolemia
Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 20 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funersi Director: After th
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Conting Physician: To the best of my knowledge death unumed at the time, date and place and due to the rause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centit 29d. Date signed (Month, Day, Year) 29c. License number

01/04/2005 25000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimole, MD. 21237 9000 Franklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Stall JAN 0 8 2007

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

200

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) _{Бау} **Physician** 2007 6:30 A. M PETER KILLEFER January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 830 W. 40th. Street 364 Baltimore N/A8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs. 84 3, 1922 California **Director** <u>558-20-9594</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 □ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 364 21211 830 W. 40th. Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1943–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Engineer Oil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Killefer ပ Wade Dorothy Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Campbell Killefer (son) 5957 Searl Terrace Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 1-8-07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nas Immediate Cause (Final pulmonary CHYVNIC OBSTVUCTIVE **Physician** DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1□ Yes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) NWO 35102 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) north CHANLES STREET BALLIMORE MARY (ant) HILAY m.D 901 DON 32. Registrar's Signature 31. Date filed (Month State 8 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OSLER DRIVE TOWSON, MARYLAND 21206

7601 OSL 32. Registrar's Signature

M. D

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		of Marylar	nd / Depa		of H	ealth a		lental Hyg	iene	0.7	00138	
			Registrar Decedent's Name (First, Middle)	Last)		061	lincale	OIL	Jean		2. Date of Dea	eg. No.		3. Time of Death	
	Physicia	an			nelma M.	Krueg	er	•			Month January	Day	Year	2:50 P M	
	/Medic Examin		4a. Facility Name (If not institution	, give street and no	umber)		4b. City, Town, or Location of Death					4c. County of Death			
	CXatilli	CI	Charlestown R	etirement	Center		Ca	aton	svill	e		Ba.	ltimo	re Co.	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.				If Under Hours		8. Date of Birth	Year)	9. Birthp	place (State or Foreign	
	Director		513-09-5180	1 ☐ M 2 K) F	87	Yrs.	MOIRIIS	Days	Hours	, WIIII,	(Month, Day May 12	,1919	Mis	souri	
1	DU 3		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	sho	5		ltimore	.	.,,		Cat	onsvi	lle				1 ☐ Yes 2 No	
	28a-1	Directo	10e. Street and Number				10f. Zip (Code			- 1	0g. Citizen of	What Cou	ntry?	
3	Sa or	<u></u>	715 Maiden C	hoige Lar	a Ant	CR506			2122	28		United		•	
	ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U		Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - American Indian,		
9	or ite		1 Never Married 2 Marr	Armed Field 1 Yes	2X No		it Yes, speci 1 □ Yes 2		n, Mexican Specify:		Hican, etc.)				
3	ours red.	d by	3℃ Widowed 4 □ Divorced	Year or	Dates:							Specia	ry:	White	
ה ו	be filed within 72 nouts after daam with the Maryland tial Hygiene. Ad other then "naturel", or items 23s or 28s-f show event, the Madical Examiter ritest be richtlied at	Completed	15. Deceden (Specify only highes	's Education of grade completed)	16a. Dece	dent's Usual kind of worl DO NOT use	Occupa k done d	ation during most	t of worki	ing	16b. Kind of B	Business/In	ndustry	
١ :	then the	m Id	Elementary/Secondary (0-12)		(1-4or 5+)		memake					Own	Home		
7 .	Hygie ther		17. Father's Name (First, Middle,	<u> 1 Yea</u> Last)	ar	но	шешак	er -			(First, Middle,				
מבום	d be ental ced o	To Be	Robert Arlo		er						Christi				
	od Man	F	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	or or Rura	al Route Numbe	r, City or Town	, State, Zip	o Code)	
2	is 1 end 2 should be lied within 72 hours after dasth with the Marylan of Hem 27 is marked other then "naturel", or items 23s or 28s-f show them 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examiter rivel be rightlind at		Jacqueline K.	Breeden (I	Daughter	587	Gait	her	Road	Syk	esville	, Mary	land	21784	
D	of Her Hem		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	e)		Date	20c. Location	- City or To	own, State	
	permil. Pages Department of the Important: If Ite any Injury or of		1 Burial 2 □ Cremation Donation 5 □ Other (S)		n State					n. 1/	/26/2007	Arli	ngton	, VA	
	permit. Departm Imports any Inju		21. Signature of Funeral Service	Licensee		21	Name and	d Addres	e of Facilit		Home of				
۵	88 5 8		Sec. Sec.	<u>د</u>		7	uda-Ri 922 W:	uck ise	Ave.	Dur	ndalk, M	arylan	d 21	222	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dear							est,		Approximate Interval Between	
F	hysician		Immediate Cause (Final disease or condition	а	CI	neoni	c Xi	dru	ly f	-41	a del			Onset and Death	
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	1	. 1	0	1	- 1 (1				
	LAMITATION	_	Sequentially list conditions,	b	(or as a consec		PTIVE	H	Kery	1	4,101				
	led Islt	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that individed events.												
	be executed icien and burial-translt	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):									
2 .	w requires thet the death certilicate be executed been signed by the attending physicien and should be detached for use as tha buriat-transit	calE		d											
0	g phy as tha			J											
Š	requires that the death certifical een signed by the attending phy hould be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 ☐ Feta		∃Ectopic pre	agnancy				1	ate of deliv		
ָ מ	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (spe					М	onth	Day Year	
	et the 1 by th etach	Phy	9 Unknown			70V + 301			200		1 41 41.9	<u> </u>			
'n	res m igned bed	þ	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying ca	use give	en in Part I.	•		_		the cause of death?	
cords,	requi	Completed			1						101	es 2 No	3 [] F100	bably 4 □Unknown	
ည် ရ	The law ate has b page 2 sl	du									24a. Was a autop	SV	Were auto prior to co death?	opsy findings available empletion of cause of	
											perfor	2.2 No	1 Yes	2 No	
	Attending Physician: The law rideath. rideath. ector: After this certificate has by the funeral director, page 2 by	Be	25. Was case referred to medical examiner?	Hospital:				Othe			n (Check only or				
ō ;	Phys rahis rahdi	1.10	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier		A	4 INU	1	me 5 Resid			(y)	
5	th. • Afte	늘	1. Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Mo	nth, Day Year)	Injury	м	Bc. Injury Work	<br Yes 2 ☐						
DIVISION OF	Atter r dea ctor by the	Ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	nome, farm, st	reet, factory,	, office					ber or Rura	al Route Number,	
5	s afte	Certification:	4 Homicide	buil	ding, etc. <i>(Speci</i>	(V 1					City or Tow	n, State)			
-	To the Hospital or Attending Pr within 24 hours atten death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyir	g Physician: To the	ne best of my kno	owledge, deat	h occurred a	at the tim	ne, date an	d place,	and due to the c	ause(s) and m	anner as s	stated.	
	the H sin 24 the F the F	Medical	one)	and ma	nner stated.	ation undo a									
ı	To To Con	2	29b. Signature and title of certifie				29c.	License	number			9d. Date sign			
	10		1/1	(PC	177	1		Dange	72	1007	
	14		30. Name and address of person	who completed cal	use of death (Ite	- 6	Print)	Ch	101'4	1	ang 1	Cator	150.	,2007 1le	
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature									
	Registr	ar	JAN 0 8	2007 /	100.10	& Loss	12 18								

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

I

State

St. Patricks Drive, Suite 502, Waldorf, MD 20603

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signature

Dainty Jackson,

JAN 0 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) No Month Tok January 3,2007 4:55 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Overlea Nursing Home Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F 73 July 16,1933 North Korea 226-98-3227 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore Perry Hall 1 □Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4205 Hollow Spring Lane 21236 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Korean 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yr s College (1-4or 5+) 2 yr s self employed Grocey store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4205 Hollow Spring Lane Baltimore, MD 21236 19a. Informant's Name/Relationship (Type. Print) Mrs. Chong U. Lee - wife 20b. Place of Disposition (Name of cametery, crematory or other place)
Hilltop Service Corp. 1/6/07 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland c. 5305 Harford Rd. 21214 2. Jarbah Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that couved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUST PT しゅりかり Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

death certificate be executed

Box 68760

P.0.

Records,

Division or Vital

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "y any injury or other traumatic event, the Med once.

Examine Physician/Medical Completed Be

burial-trar and physician the as attending p ed by the a detached f signed t page 2 certificate I P this funeral After t Hospital or Attending 24 hours after death.
Funeral Director: After

25. Was case referred to medical examiner?

Certification: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

JANUARY 4

24a. Was an 1□ Yes 2☑No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

2117

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

-unn30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 0 8 2007

JAN1 2 DOWNOT 7505 15/11/50 DOIVE MM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MDGL

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 3, 2007 MARGARET **PEARCE** LE BRUN 8:00 PM 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death COLLEGE MANOR LUTHERVILLE BALTIMORE If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 06-05-1929 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2**X∷X**F 213-26-8343 77 Yrs MARYLAND Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE **JARRETTSVILLE** 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3826 SALEM CHURCH ROAD 21084 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes XX No Specify: WHITE Specify 3 ☐ Widowed XX Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) MEDICAL ADMINISTRATIVE ASSITANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GEORGE** DEWEY Le Brun MARY MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) ALEXANDER E. WELSH.III 3826 SALEM CHURCH ROAD,JARRETTSVILLE,MARYLAND,21084 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 01-05-2007 TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 4 ☐ Donation 5 ☐ Other (Specify) 10E0 VODE DOAD

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

2

MD.

Funeral

Director

7 is marked other than "natural", or thems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

Department of Health and Mentel Hygie Important: If item 27 is marked other I any Injury or other traumatic event. In

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

or Attending Physician: The law requires that the death certificete be executed attending physician end for use as the buriel-transit signed by the at Id be deteched fo been : page 2 s has

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner certificate within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

P. S. Lun (R	. G. RUTH)		SON FUNERAL	110145 5110	TOWSON, MD. 21204
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a END STAGE D				Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):			
Part II. Other significant conditions on	d	n the underlying caus	e given in Part I.	23b. Did tobacco usa 1 □ Yas 2 1 1 1	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medice! examiner?			26. Place of Dea	th (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence 6	Other (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of 28c. Injury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury or	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, of	ffice	28f. Location (Street and N City or Town, State)	iumber or Rural Route Number,
29a. Certifier 1 Certifying Phyone) 1 Madical Exam	vsician: To the best of my knowledge lnar: On the basis of examination an and manner stated.	e, death occurred at to ad/or investigation, in	he time, date and place my opinion, death occu	, and due to the ceuse(s) and rred at the time, date and pla	d manner as stated. ice, and due to the ceuse(s)
29b. Signature and title of certifier CMMfcWhosz	are/MD		cense number	,	any 4, 2007
30. Name and address of person who dead to the control of the cont	completed cause of death (Item 23a) SCARES 9944	(Type, Print) FRANK	IN SQUAR	RE DR. BAL	any 4, 2007 TIMORE, MD. 21236

State Registrar

31. Date filed (Month, Day, Year)



DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Luther William 12:15 P. [™] January 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5601 Liberty Terrace Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 20, 19 **Funeral** Days 219 54 2930 Hours 1 X M 2 □ F 56 Director 1950 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other then "naturel", or Items 23e or 28s-1 ehow 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event, the Macifiel Examinar must be nighted at Maryland Anne Arundel Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5601 Liberty Terrace 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerro Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Radio Technician Teltronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Jacob Luther ဂ္ Mary Eileen Bussler 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Claudia Emley / sister 2218F Lowells Glen Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department Importent: If eny Injury or gales. Bayview Crematory 01/05/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 pramuscushi 23a Part 1. Enter the disease, an emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Paner Fatia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year signed by the at I be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: the funeral director Be 25. Was case referred to medicat 26. Place of Death (Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Handury St. Beltimore Md 21225 UKN BCHO. 300i NO 16. 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar 2007 IAN 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔒 🗎 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 3, 2007 **Physician** 7:45 P M LEVITT SYLVIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last hirthday) 5. Social Security Number **Funeral** Months Days Hours Min. 0373171919 1□M 2**V**F MD 87 212-32-3438 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland II Hygiene. other then "naturel", or Items 23a or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or then "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 238 2434 W. BELVEDERE AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NONE NONE NONE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other treumatic event size. 17. Father's Name (First, Middle, Last) LEVITT REBECCA MITNICK PHILIP 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3410 TERRAPIN ROAD - BALTIMORE, MD 21208 NORMA LEVITT / SIS-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH(AITZ CHAIM) 1/5/07 HALETHORPE, MD 4 Donagton 5 Other (Specify) 22. Name and Address of Facility 21. Signated SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part . Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final Physician rears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 Unknown bet 1 ☐ Yes Completed 24a. Was an autopsy performed? 000000 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 🕋 Other: 4 Adursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Atter thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 29b. Signatur and title of certain person who cause of death (Item 23a) (Type Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 JAN 0 8 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RAYMOND L. MAGRUDER, Sr. **Physician** Month Year 0456 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1.0 M 2□ F 579-40-623 Director December 24, 1930 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov in then "netural", or items 23a or 28a-f eho The Medical Examinar nuest be notified at 1 Yes 2 No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 High Sheriff Trail 21811 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Byes 2 □ No If Yes, Give Year or Dates. Korean War 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Routeman permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygien Important: If Item 27 ie marked other It eny Injury or other treumatic event, Ita once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond R. Magruder Susan K. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Magruder Berlin MD Z18/1 Trail Wife 22 High Sheriff 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arxdomy Gifts Registry January 6,2007 Hazever, MD 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Antony Giffs Registry 21. Signature of Moneral Service Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** COLON CANCER omontes /Medical Examiner Security list consists if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.
To the Funerel Director: After this certificate has been signed by the attending physician and Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ NONE Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 X ER/Outpatient 3 IDOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 20 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No. investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 17. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examilier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Dale sig ed (Month, Day, Year) D0050826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAZAHIC ENIOLA 9733 HEALTHWAY PR BEREW MD

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

			1 - For State Registrar	State of Marylan		rtment of H			gienez 0 0	7 00145
	Physici	an	1. Decedent's Name (First, Middle, Last) Fern Adele Madea					2. Date of De Month	Day 2 Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c. County of D	
	Funeral		5. Social Security Number 6. Sec	3 , ,	ast birthday)	If Under 1 Year Months Days	If Under 24 H	8. Date of Bir (Month, Da		MOC Birthplace (State or Foreign Country)
ĸ	Director		163-20-5292 Usual Residence of Decedent	M 25kF 80	Yrs.	North S Days	Tiours III	Oct.29,	1926 Pe	ennsylvania
	aryland ehow	<u>_</u>	10a. State 10b. County Maryland Baltimore		, Town or Loc 1iddle					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	recto	Maryland Baltimore 10e. Street and Number	÷ r	паате	10f. Zip Code			10g. Citizen of What	
	23a o	ralD	9903 Berliner Plac	ce Apt. G		2122			USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural, or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at ances.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Milloroced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2XNo		(Specify Yes or No Jerto Rican, etc.)	14. Race - A Black, W Specify:	
Maryland 21215-0036	hin 72 ho e. en "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give k	ent's Usual Occup kind of work done of NOT use retired	during most of v	working	16b. Kind of Busine	
121	iled wit Hygiene ther the nt, the	Соп	8 17. Father's Name (First, Middle, Last)	,		Presser	18 Mother's N	Name (First, Middle,	Dry Clean:	ing
/land	wid be i Mental I wked o	To Be	Unk.	Wiea	and		Beulah		maddin comand,	
Mary	d 2 sho th and l i7 ie me		19a. Informant's Name/Relationship (Ty Cheryl Dawson (Daug	•					er, City or Town, State aryland 21	
ore,	of Heal of Heal fitem 2 r other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. P	lace of Dispos emetery, crem	sition (Name of atory or other place	ea)	Date	20c. Location - City	or Town, State
Baltimore,	it. Pag rtment rtent: I rjury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	HOJ	-	1 Mem. G	4	1/10/2007	Baltimo:	re, Maryland
B	Depa Impo		Muchail C. Sa	Alnos Sr.	Br	uzdzinsk	i Funer	al Home I Avenue Es	A. sex, Mary	land 21221
	Physician		23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final	deficient that caused the death ine cause on each line.	Do not ente	r the mode of dyin	g, such as card	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to for as a consequ	Jence of):	Panal	<u> </u>			7/1/5
	Ш	Jer	Sequentially list conditions, if any, leading to immediate	Drun 51 tw Due to (or as a consequence	uence of):	1+WCl				Toays
	cate be executed ohysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	ate be e hysicier the buri	dical	L.	l						
Box 6	ath certifi ttending or use as	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>о</u> О	res that the de igned by the a be detached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	au 5	Other (specify)				
ords, I	w requires that been signed should be de	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derlying cause give	en in Part I.		~	e to the cause of death? Probably 4 Unknown
I Rec	The law rete has be page 2 st	Completed						24a. Was autor perfo 1 \(\text{Yes} \)		
Vita	sician: s certific lirector.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ER/Outpatient	3□ DOA Oth		Death (Check only o	one) dence 6 ⊡Other (S	nonit d
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	-	27. Manner of Death 1 Natural 5 Pending Accident investigation	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work			how injury occurred	распу
Divis	tal or Atters a after de el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (: City or Tox		Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edicai	29a. Certifier 12 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certain	NO ACT	tol.	29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
,			30. Name and ad re of person who co	mpleted cause of death (Item	23a) (Type, F	RES	5 0	0000	29d. Date signed (M 01 - 06 MOSE, MO	-2007
4			31. Date filed (Month, Pay, Year)	00 9000 Fro	inklin	Square	Drive	2 Baitin	nose, mo	21237
2	Sta Registr		JAN 0 8	007	A A	case				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan **Physician** 2, 6:15 Pm Ursula R. McCoy 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year March 11, 5. Social Security Number 6. Sex if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Months Hours Min. 93 110-01-2807 191B North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 XXes 2 □ No New York New York New York Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be r United States 10013 80 N. Moore Street # 7J Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify. 2 3√√√Widowed 4 □ Divorced Specify: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Rockland State Hospital Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Ida Clark Thaddeus မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 80 N. Moore Street #7J, New York, 10013 Sandra McCoy (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery Jan 8, 2007 Hackensack, NJ 21. Signature of Juneral 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 700153 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as connequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes ¾☐ No 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 □Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 2□ N Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, M.D. 7503 Surratts Road, Clinton, MD 20735

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

			For Segistrar	State of Maryland		nt of Health and te of Death		giene 0 7	00147
	Physici /Medic Examir	al .	Decedent's Name (First, Middle, Las	crimmen	4b. Cih	r, Town, or Location of Deat	2. Date of De Month Japan	Day Year	7 1218 M
	Funeral Director	161	5. Social Security Number 6. Se	7. Age (In yrs. Ia		er 1 Year If Under 24 Hrs	8. Date of Bir	1 9. B 1 9. B 1 9. B	inthplace (State or Foreign Country) The Caroling
	Maryland e-f show	ctor	10a. State 10b. County	10c. City,	Town or Location	timore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	death with the Maryland ime 23a or 28e-f show ir must be notified at	Funeral Director	10e. Street and Number 2327 N	Charles	St.	21218		10g. Citizen of What C	A
980	hours after de turai, or iteme al Exerticar m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	i. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	pecify Yes or No to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene ed other than "natural", or iteme 23a or 28e-f show event, the Medical Exercites must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	rking	16b. Kind of Busines Batte City S	s/Industry more ehour Septem
Maryland	should be file of Mental Hy marked oth matic event	To Be (17. Father's Name (First, Middle, Last) Bonnie	Mc Crim		Raci	harL	Maiden Surname) M C D	owell
	1 and 2 s Health ar em 27 le ther trau		19a. Informant's Name/Relationship (7) Deborah 20a. Method of Disposition	Crimanon 200. Pla		ame of	Date	0	nd. 21231
Baltimore	permit. Pages Depertment of I Important: if its any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature Finer) Service Licen	Hemoval from State	das Hi		0-07 alto, n	GlenBur nd. 2122	nie, md.
			23a. Part1. Enter the disease, or compshock, or heart failure. List only of	dications that caused the death.	Gan	Pimarchf	. Home i	Balto. mi	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a conseque	ence of):				
く、0.00	sate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque C. Due to (or as a conseque					
9	. u	edical		d					
P.O. Box	death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic			23d. Date of di Month	elivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not result		•		obacco use contribute Yes 2 No 3 F	to the cause of death? Probably #dunknown
al Rec		Completed					24a. Was autoj perfo 1 □ Yes	prior to prmed? prior to death?	autopsy findings available completion of cause of s 25 No
<u> </u>	siciar certif irecto	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	D/O		ath Check only o		
Division of Vital Records,	ding P. After fune	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	14□Inpatient 2□E	R/Outpatient 3 C 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No		dence 6 Other (Sp how injury occurred	ecify)
Divis	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)			City or To		
	he Hospital in 24 hours a he Funeral i pletely filled	Medical	29a. Certifier (Check only one) Certifying Phy 2 ■ Medical Exam	rsician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death occurre on and/or investigatio	d at the time, date and place n, in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		25	c. License number		29d. Date signed (Mor	nth, Day, Year)
•	٥		30. Name and address of person who d	ompleted cause of death (Item)		D29053	5	Tonuez.	3 2007
	3		Allon J- Chre	5401 C		+ Rang			21133
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 8 200	32: Registrar's Signatu	Louis P				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Morrison David January 1, 2007 4:32 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Co. Havre De Grace
If Under 1 Year | If Under 24 Hrs. Harford Memorial Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 50 Yrs. 28,1956 Maryland Director 220-68-0434 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Edgewood Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21040 439 Barnsby Court filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or itsms 11. Marital Status 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Volunteer al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Volunteer Firefighter permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygian Important: if Item 27 is marked other ti any Injury or other traumatic svant, IIII once. 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruby C. Cuthbertson Gilbert H. Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2814 Kirkleigh Road Dundalk, Maryland 21222 Mrs. Ruby C. Morrison (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 1/4/2006 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OSTOOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ⊠No Month Year Day 4□ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

or Attending death. hours after within 24 hours at To the Funers! D completaly filled in

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date ahd place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

20215

12007

Havedo greco / MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

661. S. Umian ava / KORMO CHANDRO. 5 NAR

31. Date filed (Month, Day, Year)

29a. Certifier (Check only

2. Registrar's Signature

State Registrar

I in by t

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F		, ,	ene	7 0	0119
	Physici	an	1. Decedent's Name (First, Middle, Last)	MULL	inc			2. Date of Death Month	1	ear	. Time of Death
	/Medio		4a. Facility Name (If not institution, give s	/	. 3	4b. City, Town, o	or Location of Death		4c. County of		11:07 a ^M
	LXdiiiii	CI	Catonsville Comm				timore		Balti	more	
Mi.	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,			(State or Foreign
	Director		227-30-3192	M 280F	90 Yrs.	L. Days	1100.0	3/14/16		Virgi	nia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d.	Inside City Limits
	Many f sho	ţ	MD n/	•	R ₂ 1	timore					1 Æ Yes 2 ☐ No
	r 28e	rec	10e. Street and Number	<u>a</u>	Dai	10f. Zip Code		10	g. Citizen of Wha	at Country?	•
	th with	aD	1626 McHenry Stree	t		2122	3		USA		
	ems ems	Funeral Director		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		American I White, etc.	ndian,
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ▼N If Yes, Give	0	1 ☐ Yes 2 🗷 No		, , , , , , , , , , , , , , , , , , ,	Specify:	TTINES, SIG.	
Ö	hour: turel'	q p	3. Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dassa	tant'a Haval Occur				Whit	
7	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-1 show re Modical Examirer must be notilled at	Completed	(Specify only highest grade	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	6b. Kind of Busir	ness/indust	ry
212	d with giene	E	Elementary/Secondary (0-12)	College (1-4or 5-		ine Oper	ator	1	Marvland	Cup	Company
ğ	e file al Hyg l othe vent,	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, M			
yla	Ment Ment arkec	10	John Cox				Lilly M	lae Vanove	er		
Jar	2 she and and is m		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, Sta	ate, Zip Coo	de)
e, P	1 and Heelth em 27 ther t		Mr. Glen Cox, Sr.	/ Nepnew	20h Place of Dispo	McHenry	Street Ba	ltimore,	Marylan	d 212	223
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28e-1 show any injury or other treumetic event, if a Middied Examinet must be notified at ance.		1 🔀 Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	20b. Place of Dispo cemetery, cren						
를	iit. Partme		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	960	Loudon Pa		ery 1/8/ ess of Facility Lo		Baltimor		
Ba	Depar Impor any ir		Luga)	en la	3	620 Wilk	ens Ave.	Baltimore	e, Maryl		
			23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not ent e.	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Inte	proximate erval Between iset and Death
	Prysician	1	Immediate Cause (Final disease or condition resulting in death)	a	Hou	t CV	#			On	/ W/C
	/Medical Examiner		Tooding in doutin	Due to (or as a	consequence of):	AL.	1 Fil.	211.1.			V
1		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	Ma	1 56-	11/05		-	779
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			MM	1				yy
oʻ	a exec an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed oblysician and the burial-transit	dical		d							
9		Mec	IF FEMALE:	20 16 1100 01400000						-	
Вох	eath certifi attending p for use as	lan	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	у		23d. Date of Month		y Year
o.	that the de ned by the a detached t	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	mile or death 5	Other (specify) _					
<u>α</u>	The law requires that the death certificate has been signed by the attending tragge 2 should be detached for use as	by Physiclan/Me	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribu	ute to the ca	ause of death?
rds	v requires been sign should be	ed b						1 ☐ Yes	3 2 □ No 3 I	☐ Probably	4 dunknown
Records,	law requas been 2 should	Completed						24a. Was an		re autopsy	findings available
œ.	icien: The lav certificate has rector, page 2	mo.						autopsy perform	ed? 🖊 dea	ith? Yes 2	etion of cause of
Vital	ysicien: The is certificate his director, page	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one			
	S S	ဥ	1 ☐ Yes 2 ☐ No	fospital: 1 Inpatier		IL 3 DOA		ome 5 Resider		(Specify)	
Division of	Attending Physicien: r death. ector: After this certific by the funeral director.	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wor	ryat rk? Yes 2 ∐No	28d. Describe hov	v injury occurred		
isi	Attende death ctor:	fical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Iniu	ry - At home, farm, str		105 2 100	28f. Location (Stre	ent and Number	or Rural Ro	ute Number
2	in Direct	Certification;	4 Homicide determined	building, etc.	(Specify)	oot, radiory, diffee		City or Town,		-, 110/0/110	
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral in the f		(Check only 2 Medicel Exami	sicien: To the best oner: On the basis of	f my knowledge, death examination and/or inv	n occurred at the tir	me, date and place,	and due to the cau	use(s) and mann	er as stated	d.
	thin 2, the I mplet	Medical	one) 29b. Signature and title of certifier	and manner stat	Del at	29c. Licens					
)	5 ¥ 5 8		DAIC 1	~~ "	My	250. Licens	7694	12 7	d. Date signed (#	tionii, Day,	2007
	1		30. Name and address of person co	mnleted cause of de	ath /Itam 22al /Time	Print)	3011	V	0	/	,
7	l		R TURAKAIA	MO 10	79, Wel	brick &	3694 20. Cato	rywille,	MD:	2/22	2 8
	Sta	ite	31. Date filed (Month, Day, Year)	007	r's Signature		·				
	Registr	ar	JAN 0 8 21	101/ pt 3000	in it is	A Charles					

ev Cates	R	For State	ate of Maryland	-	cate of Death	na Mental I	Re	g. No.	200	7 0015
Physician edical Examine	•	. Decedent's Name (First, Middle Adev Oates	e,Last)				2. Date of Deat Month January 4,	Day	Year	3. Time of Death 1550 hrs
	4	a. Facility Name (if not institution Northwest Hospital	n, give street and number)		4b. City, Town, o	r Location of Dea		4c. Cou	nty of Death	ntv
Funeral Director	4	Social Security Number	6. Sex 7. Agr	e (In yrs. last bi	rthday) If Under 1 Ye Months Da			h(MM/DD/Y	YYY) 9. Birti	hplace (State or Maryland Intry)
v any	_	Usual Residence of Decedent Oa State 10b. County		10c. City, Tow	n or Location					10d Inside City Limits
Maryland 28a-f show at at once.	2 1	Maryland Ba Oe. Street and Number	ltimore		Windsor Mi	1	110	a Citizen o	f What Coun	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.		7004 Gavmount	Road		21244			U.S.A		
r death with 1	1	1. Marital Status 1 X Never Married 2 M	arried 12. Was Decedent Armed Forces?		13 Was Decedent of H If Yes, specify Cuba				Race - Americ Vhite, etc.	can Indian, Black,
rs after d	2	3 Widowed 4 Div	orced If Yes, Give Year or Dates:		1 Yes 2 X N		f work done	_	of Business/Ir	
5-0036 ed within 72 hour lygiene other than "natu		Elementary/Secondary (0-12)	College (1-4 or		during most of working lif			TOD KING O	n business/ii	idustry
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	1	0 7. Father's Name (First, Middle,	Last)		NONE	18.Mother's Nar	me (First, Middle, N		ONE ame)	
1215 d be file lental H arked arked event, t	ב ב	William Haywoo	d Oates		0) 44 %		aria Ragl			
MD 21 nd 2 should alth and Me on 27 is ma ranmatic ev	- 1				9b Mailing Address (Stre					
s l a	12	Veda Maria Rag 20a. Method of Disposition 1 V Burial 2 Cremation		20b. Place	004 Gaymount of Disposition (Name of catory of Letter place)	emetery,	Date			
	_	1 X Burial 2 Cremation 4 Donation 5 Other S 5 Signature of Funeral Service		Arbut	122 Name and Addres	Come 01	/13/07	Balti	more,	e, MD Maryland
Balti permit Departi Import injury		Sull of			22. Name and Addres	HOLS. A	ve., ватт	limore	, Mary	F/H,P.A. vland 2121
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line		not enter the mode of dying ypopanpituitari		or respiratory arre	est, shock, o	r heart	Approximate Interval Between Onset and Death
Examiner		mmediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		урораприсциал	Sill				
j		Sequentially list conditions, fany, leading to immediate	b Due to (or as a conse	equence of):						
uted d ansit		cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit bysician/Modical Ex		UNPENDED	Y AMENDED	erFH, 23	a,27,perME, g86	5, 3/22/20)07 TT			
rificate be	2:	F FEMALE 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcorne 1 Live birth	me of pregnanc		Ectopic preg		23d Dai	te of delivery	ay Year
Box 687 e death certific the attending p ed for use as the	3212	1 Yes 2 No 9 Uni		time of death	5 Other (Specify)					
P.O. Bc s that the de- med by the s detached fe	2	Part II. Other significant condit	ions contributing to deat	h but not result	ing in the underlying cause	given in Part I.				the cause of death?
Division of Vital Records, P.O. rat of vital Records, P.O. rat or Attending Physician: The law requires that it is after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted by the proposition of the completed by the proposition of the p	neted						24a Wasa	an 2	4b Were aut	topsy findings available
Reco	O D						_ autop: perfor 1 ✓ Yes	med?	death?	ompletion of cause of s 2 No
ital Financian: secretification.	ou li 4	25 Was case referred to medica examiner?	Haspital:			Other				
of V g Phys fter this neral di		1 ✓ Yes 2 No 27 Manner of Death	28a Date of Inju	ent 2 V ER/		ury at Work?	sing Home 5 28d Describe h	Residence now injury oc		· · · · · · · · · · · · · · · · · · ·
ttendin death rtor: A v the fur	ation	1 X Natural 5 Pene 2 Accident Inve	(Month, Day, Y ding stigation	rear)	1	Yes 2 No				
Division ital or Attendus after death all Director:	21		ld not be rmined (Specify)	njury - At home,	farm, street, factory, office	building, etc.	28f. Location (S or Town, S		umber or Rui	ral Route Number, Cit
	ਰ 1	29a. Certifier 1 Certifying P	hysician: To the best of m miner:On the basis of exa and manner stated							
	Me	29b. Signature and title of certific	7 77	M.		se number			signed (Mor	nth, Day, Year)
18	1	30. Name and address of person Susan Hogan MD.	who completed cause of c Assistant Medical E) 111 Penn Street, Ba	Itimore, MD 2	21201			
Stat	~~	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Louiste)	-,				
Registra	T.	JAN V	8 2007 /	Stade Stade	Page 1	· ·				

	1	For State Registrar	State of Maryland		nent of Health and cate of Death		giene 0 0 7	00151
	-	. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
hysician /Medical		Harmon Pa	ir, Jr.			January	1,2007	5:30 AM
xaminer		a. Facility Name (If not institution, give s	treet and number)	4b.	City, Town, or Location of De		4c. County of Death	
		NMS Health Care	7. Age (In yrs. last	hiethelass) If I	Hagerstown			1-2
neral	1	6. Sex	(M 2 F 59		nths Days Hours M		(Year) Co	nplace (State or Foreig untry) hington DC
ctor		577-64-0819 12				1.00.0034	·	/////
4	-	0a. State 10b. County	10c. City, T	own or Locatio	n			10d. Inside City Limits
event, the Medical Examination was be notified at event, the Medical Examination of the Completed by Funeral Director	2	Maryland Washing.	ton	Hag	gerstown			1 ☐ Yes 2 🔯 No
red re	5	Oe. Street and Number		11	of, Zip Code		10g. Citizen of What Co	-
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2	14104 Marsh F	ike		21740		USA	
Funeral Director	5	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
II N	2	1 Never Married 2 Married	1 ∐Yes 2.XNo ‼fYes, Give	10	res 2 No Specify:		Specify:	ani
À	3	3 Widowed 4 Divorced	Year or Dates:	ISa Dagadant's	Usual Occupation		16b. Kind of Business/	Industry
Completed		15. Decedent's Edu (Specify only highest grade		(Give kind	of work done during most of I IOT use retired)	working	TOD. TAILE OF ELECTROSE	
9	2	Elementary/Secondary (0-12)	College (1-4or 5+)		e Bus Drive	ے د	Transpor	tation
		17. Father's Name (First, Middle, Last)	1/2		All the second s	Name (First, Middle,	Maiden Sumame)	
S S S		Harmon Ed	gar Pair		Edno	a Louis	e Noble	
F		19a. Informant's Name/Relationship (Ty		19b. Mailing Ad	Idress (Street and Number or	Rural Route Numbe	er, City or Town, State, 2	Zip Code)
Traumetic	1			534 W	est Franklin S	+. Hager	stown, MD	21740
	-	20a. Method of Disposition	20b. Plac	e of Disposition	n (Name of ry or other place)	Date	20c. Location - City or	
5		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State	ғолы <i>С</i> әді	ts Registry Jan	241,2007	Hanoveri	MD
i ej	1	21. Signature of Funeral Service Licens		22. Na	me and Address of Pacility	Anatemy !	Gifts Regis	itry
eny injury or ot once.		136		752	2 Connelley Da	TIVE SUIDE P	Hanover, r	nD 21076
	+	23a. Part1. Enter the disease, or compl	cations that caused the death.					Approximate Interval Between
		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.					Onset and Death
an cal		disease or condition resulting in death)	Due to (or as a consequen	come	Parterin P	878		10 1000
er			240 10 (01 40 4 0011004401			×		
.	a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):				
1 2	Examiner	Cause (Disease or injury	o					
E A	EX	resulting in death) Last	Due to (or as a conseque	nce of):				
Ine Durar marsin	g		d					
2 2	Physician/Medical				-	-		
Population of the second	2	23b. Was decedent pregnant	3c. If yes, outcome of pregnance 1□Live birth 2□Fetal de	y eath 3⊡Ect	opic pregnancy		23d. Date of de Month	livery Day Year
o o o o o o o o o o o o o o o o o o o	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea 9☐Unknown		ner (specify)		Morita	Day Four
1	Š.	9 Unknown						
1	S I	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the under	lying cause given in Part I.		obacco use contribute to	
				-		_ '''	Yes 2□No 3□Pi	Obably 4 Gotiknow
	Completed					24a. Was	osy prior to	utopsy findings availab completion of cause of
,	E					perfo	ormed? death?	2 No
	o ·	25. Was case referred to medical				Death Check onl		
5 5	0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ Ef	R/Outpatient	B□ DOA Other: 4 Nursin	ng Home 5 🗆 Resi	dence 6 Other (Spe	cify)
5 5	Ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
in e	atic	2 ☐ Accident investigation			M 1 ☐ Yes 2 ☐ No			
	≅	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, street,	factory, office	28f. Location (: City or To	Street and Number or R wn, State)	ural Route Number,
	Certification:							
		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Exam	sicien: To the best of my knowliner: On the basis of examination	ledge, death oc	curred at the time, date and p igation, in my opinion, death o	lace, and due to the occurred at the time,	date and place, and due	s stated. e to the cause(s)
completely lilled in by the funeral director, page	edical	one)	and manner stated.				29d. Date signed (Mon	
	Σ	29b. Signature and title of certifier	~0		29c. License number D (80(9)		JAW 2	
					- (00(9			200)
		30. Name and address of person who o	ompleted cause of death (Item 2	23a) (Type, Prir	nt)	017011	~ M 1)	21740
`		VASANT DAT-			LST HAGE	RS COW		- , , , , ,
State		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	les de la les	•			
gistra	ır	IAM 0.8 2007	Black of the	ALCO COMPANY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Parker 03 Physician JÄN 00 02 AM 200-/Medical 4b_City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner baltimore Moryland niversity of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Whenth, Day 5. Social Security Age (In yrs, last birthday).
Yrs. 6 Sex Number ce (State of Foreign **Funeral** Months 1 ■ M 2 🖫 Director Usual Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Town or Location 10d. Laside City Limits is marked other then "natural", or items 23s or 28s-f show sumstic event, the Niscipal Examinar must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 212 No Baltimore, Maryland 21215-0036 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
Give kind of work done during most of working
life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) adia r's Name (First, Mide Be 2 Mailing Address (Street and Number or Rural Route Number permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 ie
any injury or other trau 206. Place of Disposition (Namenof 20a. Method of Disposition 1 Burial Cremation 3 Pemoval from State 5 ☐ Other (Specify) uneral Service Licensee 21. Signature of 22. Name and Address of Facility Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ntracerebra **Physician** /Medical Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or as a consequence of) To the Hospital or Attending Physician: The law requires thet the death certificete be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 105 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) #15818 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Baltimore, Maryland 22 South Greene Street, chi 31. Date liled Month, Day, Year) 32 Registrar's Signature State JAN 0 8 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland /		artment of			ınd Me		jiene	007	00153
			Decedent's Name (First, Middle	1						2	. Date of Dea		Year	3. Time of Death
	Physici /Medic	les	Lerlyn	Pottinger							Jan	3	, 2007	7:22 4
	Examin	iei	4a. Facility Name (If not institution		11.	• •	4b. City, To	_ /					Sounty of Death	11
	Funeral		5. Social Security Number		e (In yrs. last	birthday)	If Under 1	Year	If Under 2		. Date of Birth (Month, Day		9. Birth	place (State or Foreign
	Director		070-94-2622	1 □ M 2 🕅 F	74	Yrs.	Months [Days	Hours	Min.	July 17	, 19	32 Jama	aica
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	the Marylar 28e-f show	ţ	Maryland Anne	Arundel		C	dentor	1						Yos 2 □ No
	or 28e	Director	10e. Street and Number				10f. Zip C	ode				10g. Citize	en of What Co	untry?
	ath wi	rai	311 Eagle Land)3		113		1-0 (0	f><		maica 4. Race - Amer	ican Indian
	ter de ritems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces? ied 1 ☐ Yes 2 📉	•		_	_	n, Mexican,	, Puerto Ri	fy Yes or No- can, etc.)	,	Black, White	
036	rel', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1∐Yes 2Ž	∆ No	Specify:			٤	Specify: B	lack
215-0036	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28e-f show ta Mazical Examinar must be rudified at	Completed	15. Deceden (Specify only higher		16	(Give	dent's Usual of work DO NOT use	done di	urina most	of working		16b. Kind	d of Business/l	ndustry
212	filed withir Hygiene. other than ent, the M	дшо	Elementary/Secondary (0-12) 8th	College (1-4or	5+)		rvisor					Cann	ing Fa	ctory
pu	e filed al Hygi I other vent, I	BeC	17. Father's Name (First, Middle,	Last)	•				18. Mother	r's Name (First, Middle,	Maiden S	lumame)	
Maryland	nould be f I Mental I narked of natic eve	To	Lincoln	Perry						Lva		ncan		
Mar	d 2 sho th and 7 is mu treums		19a, Informant's Name/Relations		1								Town, State, Z	MD 21113
	iges 1 and 2 should be filed within 72 hours after death with the Maryla ni of Health and Mental Hygiene. If item 27 is merked other than "naturel", or items 23a or 28e-f show or other treumatic event, it a Medical Examination at Italiana at		Jennifer Bamba/ 20a. Method of Disposition		20b. Place	of Dispo	sition (Name matory or other	of		Dat			ation - City or	
ш	Pages nent of ant: If it		1 XBurial 2 □ Cremation '4 □ Donation 5 □ Other (S				lemoria			1/13/2	2007	Kin	ston, J	amaica
Baltimore,	permit. Pages Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service	Licensee	M00957	Dc 7	2. Name and naldsc .411 Ar	Addres on F inap	s of Facility unera olis	1 Hor Road	ne & Ci Odeni	cemat	ory, P Maryla	.A. nd 21113
	*		23a. Part Enter the disease, or shock or heart failure. List	complications that cause	d the death. D									Approximate Interval Between
H	Pnysician	8	Immediate Cause (Final disease or condition resulting in death)	-a. Pulmo	wy	2	160li							Onset and Death
	/Medical Examiner		rosuming in assum,	Due to (or as	a co sy lueno	ce of):								
1 1/2	/n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequenc	ce of):								
K	and -transit	Examiner	cause. Enter Underlying Cause (Ulspace or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	ce of):								
1760,	ate be executed hysician and the burial-transit	icai E	-	d		.,.								
99	requires that the death certificate be exec een signed by the attending physician an nould be detached for use as the burial-th		IS SERVING	0										
Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea	ath 3[Ectopic preg					23	3d. Date of deli Month	very Day Year
0	the de y the a	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death) 5[Other (spec	ony)						
9	n requires that the de been signed by the s should be detached	by Pt	Part II. Other significant conditi	•		_		-			23e. Did to	bacco us	e contribute to	the cause of death?
ecords,	equire	ted	Removery 47	pertension, s, shock,	Resp	inato	7 5	دران.	re		1 U Y	es 2 2	Mo 3□Pro	obabiy 4 Unknown
$\mathbf{\alpha}$	elaw hasb eless	Completed	Mercel Ethision	s, brock,	Popo	~~~~	7 8.	-6	o /·		24a. Was autop perfor	sy		topsy findings available completion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:	,			Othe			Check only o			
of	Phys rthis ral dii	To :	1 Yes 2 No 27. Mann of Death	28a. Date of Inju	ury 28	Outpatie b. Time o		c. Injury Work			d. Describe h		Other (Spec	efy)
ion	Attending F r death. ector: After by the funera	atior	1 Natural 5 Pendir 2 Accident investi		ay Year)	Injury	М		:? /es 2 □ N	No				
Division of Vital	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Place of in	jury - At home tc. (Specify)	, farm, st	reet, factory,	office		28	f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospitel or Attent within 24 hours after deatl to the Funerel Director: completely filled in by the	edical C		ng Physician: To the best Examiner: On the basis of and manner s	of examination									
	To th within To th compl	Me	29b. Signature and title of certifie	1		_	29c.	License	number				signed (Month	n, Day, Year)
	1	\	1250	~	M	0		46	120		,	Jun	5, 2	007
			30. Name and address of person	who completed cause of	death (Item 23	a) (Type	Print)	,	PE.	m (obul		OIN	21044
	∳ Sta	ate	31. Date filed (Month, Day, Year,	327 Regist	Cityle rar's Signature		DX PA	-	6	11	July	16	- 10	-10.7
	Regist	rar	JAN 0 8	2007	y Sh									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3, 8:45 A Pawlowicz January 2007 Catherine Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Dundalk 801 Jeannette Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🗓 F Yrs 213-30-7262 Marýland March 14,1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Dundalk 1 □Yes 2⁄C No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or : 801 Jeannette Ave. United States 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No White 1 ☐ Yes ANO Specify Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Salesperson of Health and Mental Hygie f Item 27 is marked other in other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Janhoff William Vogel 2 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Jeannette Ave. Mr. Robert M. Pawlowicz, Sr. 21222 Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc G Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardeal Immediate Cause (Final intorction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 10ty-5: Examiner Hypertens. 1 Sequentially list conditions, in a present of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic ohstructive disease Dulmone-1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No death? 1 ☐ Yes certificate 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural Injury s after deaman all Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral I сопретегу

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

Lundalk

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aue

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H0064901

29d. Date signed (Month, Day, Year)

01-03-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 2007^{eai} Renee G. Rabbath January 4 5:00 РМ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium

| FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | Sept. 19, 1919 Baltimore 14 Sawgrass Court 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Egypt 1 □ M 2 🕅 F Director 213-68-4248 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d, Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Timonium Mď. Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21093 USA 14 Sawgrass Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3KlWidowed 4 □ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker +2 Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hindi Habib Isabelle Samne ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 14 Sawgrass Court Timonium, Md. 21093 Nicole Martinez/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-8-07 Dulaney Valley Mem. Timonium, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** NO EKS disease or condition resulting in death) /Medical s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ding physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery Was deces in the past 12 mont in the past 12 mont in Yes 2 No 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 9☐Unknown signed by the and be detached for 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1□ Yes 2 200 this certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one Hospital: 1 ☐ Yes No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death uneral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 044560 of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

30. Name and addre

31. Date filed (Month, Day, Year)

JAN 08

ISTER DIERREDR

22. Registrar's Signature

המשביום

MD

31306

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** usene 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) CITY University MARYLAND Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 175-40-1684 14,1953 PENNSYLVANIA Director MAY 53 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director WESTMINSTER MD CARROLL permit. Pages 1 and 2 should be filed within 72 hours after death with the 10 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f any injury or other traumatic event, the Medical Examination 23a or 28a-f once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21158 1151 LONG VALLEY RD. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: ģ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CPA** ACCOUNTANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WINIFRED MARGARET GROFT NORMAN RUSSEL RAGER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1151 LONG VALLEY RD., WESTMINSTER, MD 21158 WIFE PEGGY RAGER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) MEADOW BRANCH CEM. 1/11/07 WESTMINSTER al Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. E.MAIN ST., WESTMINSTER, MD 21157 254 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) **Physician** creben /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit As ystole Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 TYes 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JAN 08

DHMH 17 Rev 1/2001

BAltiMIN

30. Name and address of perso who empleted cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

			1 - For Amend #23e, Registrar	perMD, g8	63, Maryla 63, 1/23/	nd / Depa Of II Ce	artment of He rtificate of D	ealth and l Death	Mental Hyg	jiene eg. NØ. 🕦 🗎	7 [10158
	Physici	an	1. Decedent's Name (First, Middl Charles Schell						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution	n, give street and			4b. City, Town, or L			4c. County		
	3		5. Social Security Number	hints 6. Sex	Medical 7. Age (In vi	rs. last birthday)	If Under 1 Year	134r If Under 24 Hrs.	8. Date of Birth	Arne		ardal ace (State or Foreign
	Funeral Director		208-14-9457	1 M 2 □	0 , ,	Yrs.	Months Days	Hours Min.	Dec. 2,	, Year)	Country	y) ylvania
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation				100	d. Inside City Limits
	e Mary	ctor	Maryland Anı	ne Arund	e1(Glen Bu	nie					1 ☐ Yes 2X No
	with that a or 28	Director	10e. Street and Number 408 Cody Drive				10f. Zip Code	061	1	0g. Citizen of W	hat Country	y?
	death	Funeral	11. Marital Status	12. Was D	Decedent Ever in	U.S. 13.	Was Decedent of His If Yes, specify Cuban		pecify Yes or No-		- Americar	
30	filed within 72 hours after death with the Maryland Hygione. Ither than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ried 1 X Ye	es 2 No		_	Specify:	o nicali, etc.)	Specify.	k, White, et	nite
2-003 6	72 hour natura lica Ex	ted t		t's Education		16a. Dece	dent's Usual Occupat kind of work done du	tion	ting	16b. Kind of Bu	siness/Indu	ıstry
	within 7 ane. than "r	Completed	Elementary/Secondary (0-12)		ge (1-4or 5+)	life.	DO NOT use retired) Or Telecom Chief	•		United S	States	s Navv
piret.	0 = 0 %	Be Co	17. Father's Name (First, Middle,	Last)		_1			ne (First, Middle, i			
yıar	ould be I Menta narked natic ev	To E	Charles F. Sche		r			Jean Ga:				
Ma	permit. Pages 1 and 2 should by Department of Heath and Menta Important: If Item 27 is marked any Injury or other traumatic edgine.		19a. Informant's Name/Relations Anna F. Schelli		Wife		ng Address <i>(Street ar</i> Cody Drive					
ore,	jes 1 a of Hea if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal fr		Place of Disno	sition (Name of matory or other place,)	Date	20c. Location -		
Saltimor	Ilt. Pag trtment ortant: njury c		4 □ Donation 5 □ Other (S 21. Signature = Funeral Service	pectity)	A	_	n National 2. Name and Address			rlington	-	_
n	Deperment of the perment of the permet of th		> Cubence				Funeral 1630 Edmo	Home of	Catonsv	ille, Ir	ic.	m 21228
Š			23a. Part1. Enter the disease or shock, or heart failure. List	complications the	at caused the de on each line.	eath. Do not ent	er the mode of dying,	, such as cardiac	or respiratory arr	est,	- 4	Approximate nterval Between Onset and Death
	Physician /Medical	i i	Immediate Cause (Final disease or condition resulting in death)		e p & i & to or as a cons	equence of).						onset and beaut
	Examiner		Sequentially list conditions		lesoth		Α					
ď	nsit	Examiner	Sequentially list conditions, if any learning cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a cons	equence of):						
	icate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	c	to (or as a cons	equence of):		yes.		-		
28/00,	icate b	dical		d				_				
XOO	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome pf preg		Ectopic pregnancy			23d. Date	e of delivery	,
	ne dear the att thed for	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pr	egnant at time o		Other (specify)		-	Mon	th D	ay Year
ŗ	The law requires that the death ate has been signed by the attenbage 2 should be detached for u	by Phys	Part II. Other significant condition	ns contributing t	o death but not r	esulting in the u	nderlying cause given	ı in Part I.	23e. Did tol	pacco use contri	bute to the	cause of death?
ecords,	equire									<u>→ 2/17/</u> No	3 ☐ Probab	oly 4 □Unknown
ב ב	has be	Completed							24a. Was a autops perforr	g v	Vere autops rior to comp eath?	sy findings available pletion of cause of
V 150	ian: Ti rtificate rtor, pa	0	25. Was case referred to medical					26. Place of Dea		No 1	∐Yes 2	□ No
> 5	hysloi this ce	To B	examiner? 1 Yes 2 No			☐ ER/Outpatier	t 3□ DOA Other	4 ☐ Nursing H	ome 5 ☐ Reside		r (Specify)	
	rding F th. : After e funera	tlon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g (N	ate of Injury Month, Day Year)	28b. Time of Injury	Work?	at es 2⊡No i	28d. Describe ho	w injury occurre	ıd	
2	r Atter	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 206. Pla	ace of injury - At uilding, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe	r or Rural F	Route Number,
ב	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a, Certifier **Certifyin	g Physician: To	the best of my k	nowledge deat	n occurred at the time	date and place			anor se etat	
	he Hos in 24 h he Fur ipletely	Medical	(Check only 2 Medical one)	Examiner: On th	e basis of exami nanner stated.	nation and/or in	vestigation, in my opi	nion, death occu	rred at the time, d	ate and place, a	nd due to th	he cause(s)
	To t To t	Σ	29b. Signature and title of certifie	2.0	mo		29c. License r			9d. Date signed		
	11/1		30. Name and address of person	who completed c		em 23a) (Tvpe.	Print) Isthing for	7410	V	Muy	۵,2	007
	4,,		Henry FRAM		WITIMO	re WA	15Him for	1 Mc	Lical G	enter		
	Sta Registr		31. Date filed (Month, Day, Year)	2007	. Registrar's Sig	nature	P. S.					

07-00163

S

 71.			
State of Maryland	/ Department of He	ealth and Menta	al Hygiene

amuel Edward		State of Maryland / Department of Hea 1- For State Registrar Certificate of Dea	th	eg No. 2007 0015
Physici Medical Exami		Decedent's Name (First, Middle,Last) Samuel Edward Serio	2. Date of Deat Month January 6.	Day Year 4540
		4a Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death ott City	4c. County of Death Howard
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If United Security Number 1. Security Numb	der 1 Year If Under 24Hrs 8. Date of Bird	th (MM/DD/YYYY) 9 8irthplace (State or Foreign
Director		216-68-5863 1XM 2F 43 Yrs. Mont	ths Days Hours Min. March	13,1963 Country Maryland
, any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d Inside City Limits
Marytand 28a-f show any d at once,	ģ	Maryland Howard Ellicott C	<u> </u>	1 Yes 2 X No
the Mar ia or 28s	Director	11441 Butterfruit Way	21042	USA
hours after death with the Maryland natural", or itens 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spec	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, 8lack, White, etc.
fter d	by Fu	or Dates.	2 X No specify:	Specify White
C1 3 🖃	eted I		al Occupation (Give kind of work done orking life. DO NOT use retired)	16b. Kind of Business/Industry
15-0036 filed within 72 I Hygiene ad other than " t, the Medical."	Completed	4 Vice Pres		Automotive
21215-0036 ould be filed within 7 I Mental Hygiene in marked other than ic event, the Medica	Be C	17. Father's Name (First, Middle, Last) Charles R. Serio	18.Mother's Name (First, Middle, N	walden Surname)
D 21 should and Mer			SS (Street and Number or Rural Route Num	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex-	ŀ	20a. Method of Disposition 20b. Place of Disposition (No	ame of cemetery, Date	ville, Maryland 21228 20c. Location - City or Town, State
Baltimol permit. Pages Department of Important: I		4 Donation 5 Other Section Crest Lawn Me	em.Garden 1/11/2007	Marriottsville, MD
Balf permit Depar Impor		21. Signature of Funeral Service Licensee 22. Name an Funeral 1630 F	nd Address of Facility Sterling As al Home of Catonsvil Edmondson Avenue: Ca	le,Inc.
Physician /Medical		23a. Part I. Enter the disease, or complications that eaused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Narcotic intoxication Due to (or as a consequence of)		Death
,	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
(0, e be executed ysician and burial - transit		dd		
60, ate be ex physician	Medic	AMENDED #23a,PII,27,28a-f, pe IF FEMALE: 23c. If yes, outcome of pregnancy	rME, g863 1/19/07 TT	23d Date of delivery
Box 6876(c death certificate the attending phy ed for use as the b	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Sp.		Month Day Year
. Bo) he death y the att	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying		obacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	2			
ords, w requires as been as be	Completed	artery disease	24a. Was autop	prior to completion of cause of
tal Rec sian: The la certificate h		25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	rmed? death? 2
Vital hysician this cert	o Be	examiner?	Othor	Residence 6 Other Scene
on of Nading Ph	ion: T	27. Manner of Death 1 Natural 5 Pending 28a Date of Injury (Month, Day,Year) 28b. Time of Injury (Month, Day,Year)	28c. Injury at Work? 28d Describe 1 Yes 2 X No unk.	how injury occurred
Vision or Attentifier death Director;	Certification:	2 Accident Investigation Investigation Suicide 6 X Could not be Suicide 6 X Could not be	rry, office building, etc. 28f. Location (s	Street and Number or Rural Route Number, City State) I1442 Butterfruit Way
Divisior Hospital or Attend 24 hours after death Funeral Director; etely filled in by the		4 Homicide determined (Specify) House 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the second of the se	Ellicott	City, MD
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.	my opinion, death occurred at the time, date	and place, and due to the cause(s)
	Σ	29b. Signature and title of certifier	9c License number O.C.M.E.	29d Date signed (Month, Day, Year) January 7, 2007
		30 Name and address of person who completed cause of death (Item 23a)		
	tate		Baltimore, MD 21201	^
Regis	trar	JAN 0 8 2007 Jan & Jake		
DHMH 17 Rev 1/2	2001	ŐRIGINAL		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Αм 3, 2007 11:35 Sylvia Katherine <u>Semenkiw</u> January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A 3129 Northway Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 05-16-1913 5. Social Security Number Days **Funeral** Hours Months 1 □ M 2 🕱 F 93 217-22-2194 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Baltimore Maryland N/A Directo 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 3129 Northway Drive 21214 U.S.A. Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ☑ No
If Yes, Give
Year or Dates: filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Dietician Baltimore City Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filt Department of Heelth and Mental by Important: if Item 27 is marked oth eny linjury or other traumatic event RDE. Abram Erdbrink Caroline (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ted Kaelber - Son 4 Waterway Court 3A Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 01-06-2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc BAltimore, Maryland 21214 mus Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final coronary artery **Physician** arteriscleration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and for use as the burial-transit or Attending Physician: The law requires that tha death certificate be executed resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) should be deteched 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 2 No 1 Yes After this certification 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division Injury 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death.
To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 121022 1-4-07 Marroy Peralecte MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTO. MD. 21236 KUNALOW (4MI) 7602 BBRAIR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 8 2007 0044 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 5, 2007 6:50 PM Joseph Waters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 🔀 M 2 🗆 F Days Min 86 Yrs Pennsylvania 206-14-8235 Director May 24, 1920 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at N/A 1 X Yes 2 No Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant If item 27 Is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be rury or other traumatic event, the Medical Examiner must be remy. 21210 U.S.A. 911 W. LAke Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Priest Church 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Charles Ε. Waters Ε. Ryan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fellow St. Joseph Society Sacred Heart - Priest 1130 N. Calvert Street Baltimore, MD 21202 Department of Health Important: If item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 1/10/07 | Baltimore, MD 21. Signature of Funeral Service L 22. Name and Address of Facility Baltimore, Maryland 21214 5305 Harford Rd. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause out, ach in Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** New /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 9 I Inknown 9 Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has be lirector, page 2 s autopsy performe 2 No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1. Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

3 0 MAL

2007

8

31. Date filed (Month, Day, Year)

6

mo

opmpleted cause of death (Item 23a) (Type, Print)

327 Registrar's Signature

			For State Registrar	State of Ma	ryland / L		rtment of H Hificate of L		Menta	ıl Hygier Reg. I	2007	00162
9	Dhyalair		Decedent's Name (First, Middle, Last	st)					2. Dat	e of Death	Day Year	3. Time of Death
	Physicia /Medic			sephine	М.		Wallace			uary 1	, 2007	2:20 P M
	Examin	er	4a. Facility Name (If not institution, give Severna Park Ger				4b. City, Town, or		th		4c. County of Dea	
	Funeral		5. Social Security Number 6. S		(In yrs. last bir	thday)	Severn	a Park If Under 24 Hrs	8. Date	e of Birth	Anne Ar	
	Director		337-16-0872	□M 2対F 86		Yrs.	Months Days	Hours Min.		nth, Day, Yea ne 29,		thplace (State or Foreign ountry)
	pui "		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Maryla f sho	ю			roo. ony, row		auon	27-14-1	. 1			1 □Yes 2X No
	r 28a	Director	Maryland Balt: 10e. Street and Number	imore	3.1		10f. Zip Code	Notti	ngnam		Citizen of What C	ountry?
	th with	alD	9005 Kilbride Ro	oad			212	36			United S	tates
	tems rer mi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Ye	s or No- etc.)	14. Race - Ame Black, Whi	
36	be filed within 72 hours after death with the Maryland Hylyiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	0	11	□Yes 2월No	Specify:			Specify:	White
5-0036	'2 hou natura ical E		15. Decedent's Ed (Specify only highest gra	lucation	16a.		ent's Usual Occupa			16b.	Kind of Business	/Industry
Z	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. Do	O NOT use retired)	uning most of wo	rking			
7	filed within Hygiene. Ither than '	ပိ	12 Years 17. Father's Name (First, Middle, Last)				<u>Housewif</u>	e 18. Mother's Nar	mo (Firet	Middle Maid	Own Ho	me
and	d be fi	o Be	Donald E. Main						nie (<i>riisi,</i> vieve		avoran	
ar _Z	2 should be and Mental is marked raumatic ev	၉	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing	Address (Street a					Zip Code)
, Mar	and 2 salth a 127 is		Brian Wallace, M	.D. (Son)		9005	Kilbrid	e Road	Nott	ingham	, MD 21	236
ore,	ges 1 t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Removal from State	20b. Place of cemete	f Disposi ry, crema	tion (Name of atory or other place	9)	Date	20c.	Location - City or	Town, State
Saltimor	t. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify		Hillte		ervice C		4/200	7 T	owson, M	aryland
a C	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licen				Name and Address da-Ruck 22 Wise A		Ноще	of Du	ndalk, I	nc.
19		d	23a. Part1. Enter the disease, or compshock, or Peart failure. List only	olications that caused t	the death. Do i	not enter	the mode of dying	ye. Du ,, such as cardia	naalk c or respir	atory arrest,	/land 2.	Approximate
	Physician		Immediate Cause (Final disease or condition	one cause on each line			awk					Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	a. Due to (or as a			0. 00 1.			-		
		_	Sequentially list conditions,	b. — Due to (or as a	consequence	of):						
٦	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 40 4	oonooquenoo	017.						
Ď,	an ar	Exa	resulting in death) Last	Due to (or as a	consequence	of):						
09/90	ficate be executed physician arcust the burial-transit	edical	•	d								
			IF FEMALE:	23c. If yes, outcome p	of pregnancy							
202	death atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 To	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death		Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
	t the c by the	hysi	9 Unknown	9□Unknown								
Š,	The law requires that the death certil te has been signed by the attending bage 2 should be detached for use a	by P	Part II. Other significant conditions of	ontributing to death but	t not resulting ir	the und	lerlying cause give	n in Part I.	236			the cause of death?
ecoras,	requir	ted								1 □ Yes	2 No 3 P	robably 4 Abunknown
	a 850	Completed							248	a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
	in: Th	ပို	25. Was case referred to medical	 .						Yes 2		2 🗆 No
>	ysicia is cert direct	To B	examiner?	Hospital: 1 ☐ Inpatien	ıt 2 ☐ ER/Ou	tpatient	Otho	26. Place of Dea			6 □Other (Spe	city)
5	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	/ 28b. 7	Fime of njury	28c. Injury Work			scribe how in		ony)
VISION	tendl leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				M 1□Y	es 2□No				
5	I or At after o Direc I in by	Certification:	4 Homicide determined	28e. Place of injur building, etc.	y - At home, fa (Specify)	rm, stree	et, factory, office		28f. Loca City	ation (Street or Town, Sta	and Number or R ate)	ural Route Number,
_	spital nours neral y filled		29a. Certifier 1 Certifying Ph	ysiclan: To the best of	f my knowledge	, death	occurred at the time	e, date and place	e, and due	to the cause	(s) and manner as	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examone)	niner: On the basis of e and manner state	examination an	d/or inve	estigation, in my op	inion, death occu	urred at the	e time, date a	and place, and due	e to the cause(s)
	To t To t	Ž	29b. Signature and title of dertifier	1111			29c. License	number 2 4 3 6		29d. E	Date signed (Mont	h, Day, Year)
	70	-	1) When	~~~						1	113/20	
)		30. Name and address of person who		ath (Item 23a) (erch or	ive a	losh	u. M	0216	19
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrar		1	M. a					
	Registra		JAN 0 8 20	167 July 1	. 289	16263						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Ma		artment of H	ealth and Mental Death	Hygiene	007	00163
			Decedent's Name (First, Middle, Last)			2. Date Mont	of Death	Yeer	3. Time of Death
	Physicia /Medic		LEO WILLIA	MS		JAN		2007	2:15 PM
	Examin		4a. Facility Name (If not institution, give street and number)		*	Location of Death		County of Death	
			1 Short Lane		Baltimo			Baltimore	
	Funeral		1574 2015	(In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date (Mont	of Birth h. Day, Yea <i>r)</i> 22, 192	Coun	lace (State or Foreign
	Director	-	220 20 2985	19 113.		Aug.	22, 192	7 Mary	land
	land ow	_	10a. State 10b. County	10c. City, Town or Lo	cation			1	Od. Inside City Limits
	Mary Fish	ţō	Maryland Baltimore	Baltimo	re				1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number		10f. Zip Code		10g. Citiz	en of What Coun	itry?
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examiner must be notified at	aiD	1 Short Lane		212	.19	J	J.S.A.	
	deat ems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, et	or No- 1	4. Race - Americ Black, White,	
98	or It		1 Never Married 2 Married 1 X Yes 2 N	io	1 ☐ Yes 2 🗓 No	Specify:	1	Specify: Whi	te
8	ural',	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		dent's Usual Occupa	ation	16h Kin	nd of Business/Inc	fuetni
7	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	luring most of working	100. Kil	id of Dusiness/inc	lustry
12	tiled within Hygiene. ther than ant, the We	mo	Elementary/Secondary (0-12) College (1-4or 5	+) Mach	ninist		Ra	ailroad	
b	tilled Hygi other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, M	liddle, Maiden	Sumame)	
Maryland 21215-0036	ges 1 and 2 should be tiled within 72 ho it of Health and Mental Hygiene. If item 27 is marked other than "natur or other treumatic event, the Mudical	To B	Ernest I. Willi	ams		Rose Marne	ette Fo	rrest	
an	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print)	51		and Number or Rural Route I			
	1 and 2 Health tem 27 i	3	Mark Williams / Son		ort Lane	Baltimore,			
ore	Pages 1 ar nent of Hea ent: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other plac			cation - City or To	
Ë	Pag tment tent:		'4 □Donation 5 □ Other (Specify)			ark 01/06/200			
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licenses	27	2. Name and Address 001 Ritch	is or Facility Gonce I Le Highway Ba	Tuneral 1timore	Service e, Maryl	, P.A. and 21225
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	er the mode of dyin-	g, such as cardiac or respira	ory arrest,		Approximate Interval Between Onset and Death
N.	Pnysician	10	Immediate Cause (Final disease or condition	NIA					WEEK
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):					
		<u></u>	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying	a consequence of):					
	uted 1 Insit	Examiner	Cause (Disease or Injury						
Ć	be executed Sician and burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
760,	death certiticate be executed e attending physician and id for use as the burial-transit	cal	d						
9	titica ng ph as th		IE EE LANG.						
Box	eath certitica attending ph for use as th	an/h		2 Fetal death 3	Ectopic pregnancy		2	3d. Date of delive Month	ory Day Year
	ne death the atte	Physician/Med	1 Gregorian at 1 Greg	time of death 5	Other (specify)		-	77701147	24,
P.0	ac o	Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I. 23e.	Did tobacco us	se contribute to th	ne cause of death?
ds,	signed b	d by	STROKE , ATRIAL FIBRILL		, ,		1 ☐ Yes 2 2	KNo 3□Prob	abiy 4 DUnknown
20	w requir been s	ete		, , , , ,	· · · · · · · · · · · · · · · · · · ·	24a	Was an	24b. Were auto	psy findings available
Vital Records,	he lav e has	Completed by					autopsy performed?	prior to con death?	mpletion of cause of
<u>ra</u>	ician: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Death (Check		1 🗆 Yes	2□ No
>	Physician: this certificated ral director, I	ToB	examiner?	nt 2□ER/Outpatier	nt 3 DOA Oth	ar .		G ☐Other (Specif	y)
ا o	Jing Ph n. After th tuneral	T:u	27. Manner of Death 28a. Date of Inju	ry 28b. Time o	f 28c. Injun Worl	at 28d. Des	cribe how injury	occurred /	
io	Attending ir death. ector: After by the tune	atic	2 Accident investigation			Yes 2 □ No			
Division	or Attence death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	reet, factory, office		tion (Street and or Town, State)	d Number or Rura	I Route Number,
Ω	ospitel or Attendi hours after death. unerel Director: A ly filled in by the to		29a. Certifying Physicien: To the best	of my knowledge deat	h occurred at the tin	ne date and place and due to	o the cause(s)	and manner as si	tated.
	24 F = 6	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	ivestigation, in my o	pinion, death occurred at the	time, date and	place, and due to	the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier		29c. Licens			e signed (Month,	Day, Year)
			Junta Hanaler	MD	D6	2032	JANG	JARY 3	2007
10	11		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print) BAYVIEN (IRCLE, BALTI	WORE,	MD	21224
	Sta	tė	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature					
	Regist	rar	JAN 0 8 2007 Estate	. It for	and I				
DH	MH 17 Rev 1/2	001							

DHMH 17 Rev 1/2001

07-00178 Ray Alston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First_Middle Last) 2. Date of Death Time of Death Medical Examiner January 6, 2007 2324 hrs RAY ALSTON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death University Hospital Baltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth/MM/DD/YYYY **Funeral** 9 Buthplace (State or Director Months Days Hours Foreign Country) 213-96-5205 27 03/04/1979 MD Usual Residence of Deceden Ė 10b. County 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. 1 X Yes 2 N/ABaltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 5823 Waycross 21206 USA Funeral 12. Was Decedent Ever in U.S. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack, Armed Forces 1 X Never Married 2 Married White etc 2 X No Yes If Yes. Give Year Widowed 4 Divorced 1 Yes 2 X No specify. Specify. Black "natural", 2 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ages 1 and 2 should be filed within 72 Prof Health and Mental Hygiene.

11: If item 27 is marked other than "ryother traumatic event, the Medical E College (1-4 or 5+ Baltimore, MD 21215-0036 Unemployed None Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Ray Alston Maria Whiting 2 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Whiting /mother 5823 Waycross Road,Baltimore, Md. 21206 20a. Method of Disposition Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Pages 1 crematory or other place) 1 X Burial 2 Cremation 3 portant: ury or ot Western Cemetery Other Spec 1/13/2007 Baltimore, of Funeral 22. Name and Address of Facility step Brothers Fu 300 Eutaw Place. Funeral Service. Se. Baltimore, Md PA 21217 Physician art I. Ente ne disease, or co the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval nly one cause on each line Between Onset and /Medica a Multiple Gunshot Wounds Death Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of deliver 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? 2 Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₽ Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate Yes 2 ✓ Yes 2 25 Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 ۵ 1 🗸 Yes 2 No Manner of Death 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? within 24 hours after deau.

To the Funeral Director: A Subject was shot Natural **FOUND** 5 Pending Yes 2 V No Certificati Jan 6, 2007 2 2250 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 300 W. North Avenue, Baltimore, MD determined (Specify) Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number mi mo O.C.M.E January 7, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day AGMOND JANUAN 200 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE ANAAUSTEWN 1100 CENTO 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 11**2**(1) 2□ F Feb 17, 1958 Maryland 216-78-3047 48 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∐¥es 2 □ No **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 222 Mt. Holly Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 1 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David W. Anderson Mary M. Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Dartmouth Avenue Baltimore, Maryland 21234 David Anderson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 🖟 uriai 2 □ Cremation 3 □ Removal from State 01/11/07 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Sign of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Fart 1. Enter the disease, or complications that caused the death. shock, or / sart failure. List only one cause on each line. Immediate Carve (Final disease or condition resulting in death) Due to (or as a consequence) Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 21110 24b Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Death of the completion of cause of death? 24a. Was ar autopsy performe 25. Was case referred to dical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 ER/Outpatient 3 DOA 1 Dipatient 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 2 Accident

Examiner death certificate be executed as the burial-tra physician attending p

o

₫.

Records,

Division or Vital

signed by the a has le 2 page certificate director

funeral

After

Hospital or Attending

Physician

/Medical

Director

Funeral

Completed by

Be

ပ္

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Saltimore,

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

of Health and Mental Hygiene.

permit. Page Department o important: If a

Physician /Medical

other t

= 5

Physician/Medical Completed by Medical Certification: To Be

Examiner

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

within 24 hours after death

To the Funeral Director:..
completely filled in by the f

State Registrar

29b. Signature and title of certifier

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 19502 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDE 31. Date filed (Month, Day, Year) JAN 0 9 2007

ANDAR 32. Begistrar's Signature

Baltimore, Maryland 21215-0036		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at	Funer	->.<:

			For Stata Registrar	oraro or marylan	Cei	tifica	te of Death			ag. No.	00100
			1. Decedent's Name (First, Middle, Last)	+ - 3 - 1				Date of Deat Month	th Day Year	3. Time of Death
	Physici /Medic	~	Nancy 1	Lee Applega	arth				Jan	5 2007	10:42 AM
)	Examin		4a. Facility Name (If not institution, give	street and number)			, Town, or Location of			4c. County of Death	
			2134 Southorn				Middle R			Baltimo	
ı	Funeral Director		210-40-1543	x		Months	r 1 Year If Under 2 Days Hours	Min. S	Date of Birth (Month, Day, ept.	9. Births 20, 1944 MA	place (State or Foreign Try) Tryland
	and		Usuel Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Maryl Sa-f sho	ctor	MD Balt:	imore M	Middle	Ri	ver				1 Tyes 2 1/No
	th with th	Funeral Director	2134 Southorne	e Road		10f. Z	21220		1	USA	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show styr injury or other traumatic event, the Medical Examinar must be multified at ODGE.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:			edent of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Origonal Code of Hispanic Original Code of Hispanic	gin? (Specify , Puerto Rica	y Yes or No- an, etc.)	14. Race - Amend Black, White, Specify: Whi	etc.
Maryland 21215-0036	thin 72 h e. en "natu Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of w	ual Occupation ork done during most use retired)	of working		16b. Kind of Business/In	dustry
2	Agient Agient The th	Con	12th		Mar	age				Tavern	· · · · · · · · · · · · · · · · · · ·
and	uld be fill lentel H rked oth	To Be	17. Father's Name (First, Middle, Last) Robert Wendel.	l Sr.					irst, Middle, i Geisle	Maiden Sumame) ⊇r	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Addres	s (Street and Numbe	r or Rural R	oute Number	r, City or Town, State, Zip	Code)
Σ	and 2 salth n 27 i		Karrie R. Car				CONTRACTOR OF THE PARTY OF THE				
Baltimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specify,	Removal from State		natory or 7 Cr	other place) ematory		7	20c. Location - City or To Baltimore	MD
Balt	permit. Departuimport Import		21. Signature of Puneral Service Licens	Carrelly h	22					Ave.Balto	
			23a. Part 1 Enter the disease, or composhock, or heart failure. List only	lications that caused the deat	h. Do not ent	er the mo	de of dying, such as	cardiac or re	spiratory arr	est,	Approximate Interval Between
I	Physician		Immediate Cause (Final disease or condition	, A	140c	AKI	DIAL IN	FAR	C7161	V	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	mence of):		ONARY A				
).	Sequentially list conditions,	b. SEVE		2012	01/2/11-7	KICK	-1 21	367/36	
-	uted I Insit	mlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		2-7	SION				
Ć.	rificate be executed ng physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq							
68760,	le be ysicie e bur	cal	(d							
	tifical ng ph as th	Medi	15.55141.5								
.O. Box	The law requires that the death cei ate has been signed by the ettendir bage 2 should be detached for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	ıl death 3 []Ectopic] Other (:	pregnancy specify)			23d. Date of delive Month	ery Day Year
Ω.	s that the ned by a detac	by Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying	cause given in Part I.		23e. Did to	bacco use contribute to t	he cause of death?
rds	quire an sig								1XX	es 2 □ No 3 □ Prot	oably 4 □Unknown
Records,	The lay te has age 2	Completed							24a. Was a autops perform	sy prior to co med? death?	opsy findings available impletion of cause of
ta		0	25. Was case referred to medical				26. Place	of Death (C	heck only or		
>	S S	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 🛭	Other: 4 Nu	rsing Home	5 Resid	ence 6 □Other (Specia	(y)
0	ding Ph th. After th funeral		27. Manner of Death 1 ➡Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?		I. Describe h	ow injury occurred	
Division of Vital	il or Attending after death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	286. Place of Injury - At fi	ome, farm, sti	M reet, facto	1 ☐ Yes 2 ☐ f			treet and Number or Run	al Route Number,
ā	2 8 2 2		4 Homicide	building, etc. (Special					City or Tow		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my knoiner: On the basis of examination and manner stated.	ation and/or in	h occurre vestigation	d at the time, date and on, in my opinion, deat	d place, and th occurred	at the time, d	ause(s) and manner as s late and place, and due t	itated. o the cause(s)
	To the Fo the complex	Me	29b. Signature and title of certifier	<u> </u>		2	9c. License number		2	29d. Date signed (Month,	•
	- > - 0) set	and Mo	1		D 220	620		01,08,	2007
	h		30. Name and address of person who o	completed cause of death (Item			Balt	Λ.	, k		
			31. Date filed (Month, Day, Year)	32 Segletrar's Sign		200	BALL	0.14	0		
1	St: Regist	ate rar		007	At a	MAN.	P				

07-00138	
Meghan Albaugh	

eghan Albaugi		State of Maryland / Depa 1-For State Ce	artment of rtificate of		Mental H		. 00	07 00:0	
Physici		Decedent's Name (First, Middle,Last)	rimedie er			Date of Deat Month	Day Year	3. Time of Death	
edical Exami	iner	Meghan Marie Albaugh 4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Lo	ocation of Deat	January 5,	2007 4c. County of E	1650 hrs	
)		St. Agnes Hospital		Baltimore					
Funeral Director		5 Social Security Number 219-08-3971 6. Sex 7. Age (In yrs. 219-08-3971	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir	_	i F	Birthplace (State or oreign Country) MD	
ò		Usual Residence of Decedent				100 31	1501		
Maryland 28a-f show any d at once.	L	10a. State	, Town or Location Lansdo					10d Inside City Limits 1 X Yes 2 No	
darylan 28a-f s f at one	Director	10e. Street and Number	Barisdo	10f. Zip Code		10	g Citizen of What		
ith the 1 23a or notifie		25 Fourth Ave. 11. Marital Status 12. Was Decedent Ever in U	10 142 142	21227			USA		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces? 1 Yes 2X No		Decedent of Hispa s, specify Cuban, N			14. Race - A White, e	merican Indian, Black, tc.	
	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No		work done	Specify:	White	
6 72 hou m "nat cal Exa	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life D				,	
-003 d withir giene ther thi	Completed	12 17. Father's Name (First, Middle, Last)	Sec	retary	3.Mother's Name	e (First Middle M	Ca:	r Repair	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene T's marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Be	James Jay Albaugh, II		7	Valerie	Ann Di	Giacomo		
Baltimore, MD 21215-0036 pepernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Inference τ	19a Informant's Name/Relationship (Type, Print) Valerie Albaugh, mother	25 F	ourth Ave	e. Lan	Rural Route Num sdowne,	ber, City or Town, S MD • 212			
Baltimore, MD ermit. Pages I and 2 sho Department of Health and Important: If item 27 is nijury or other tranmar		2Cb. Method of Disposition 2Cb. 1 XBurial 2 Cremation 3 Removal from State Mg	Place of Disposit	non (Name of ceme er place) ee Memor:	ial Par	Date k 01-11-	20c. Location - Cit	ridge, MD	
Iltimoranit. Pages I artment of I octant: If	2	4 Donation 5 Other Specify 21 Signature of Fuperal Service Licensee							
	et ja	23a. Part I. Enter the disease, or complications that caused the death		ame and Address of Ambrose 1328 Suli	Funeral phur Sp	Home, I ring Rd.	inc. Arbutu:	s. MD. 21227	
Physician /Medical		failure. List only one cause on each line.		e mode of dying, so	dch as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) a Methadone intoxi Due to (or as a consequence of						DOM!	
7	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of)						
_ =	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	of)						
50, te be executed ysician and burial - transi	ledical E	d. X UNPENDED AMENDED 1100 000							
760, cate be er physiciar he burial									
Box 68760, ne death certificate by the attending physic ned for use as the burned burned for use as the burned	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of december 2.2 birth	eath =	al death 3 er (Specify)	Ectopic pregn	ancy	Month	Day Year	
. 0 7 0	Phys	1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not not not not not not not not not no			en in Part I	23e Did to	hacco use contribut	e to the cause of death?	
By the gareer of e de	by		Total In the Gr		CITILITY CITY			Probably 4 Unknown	
Division of Vital Records, P.C. Ital or adtending Physician: The law requires that as after deat. After this certificate has been signed and brector: After this certificate has been signed led in by the funeral director, page 2 should be determed in by the funeral director.	Completed					24a. Was a autops	у ргю	re autopsy findings available r to completion of cause of	
Rec i: The lificate h		25. Was case referred to medical	<u>-</u>			perform 1 Yes 2		h? Yes 2 No	
n of Vital iding Physician: th : After this certif	o Be	examiner?	ER/Outpatient	-	f Death (Check		Residence 6 0	Other.	
n of ling P After funera	on: T	27 Manner of Death 28a. Date of Injury (Month, Day, Year)	28b Time of In		at Work?	28d. Describe h	ow injury occurred		
Division pital or Attencours after death reral Director:	Certification:	2 Accident Investigation Suicide 6 X Could not be Fnd 1/5/2007 28e. Place of Injury - At h	Fnd 4:12 nome, farm, street	DIII i	42	unknown 28f. Location (S	treet and Number o	r Rural Route Number, City	
Diversal ospital of hours at meral Diversal property y filled		4 Homicide determined (Specify) found	l t reside			Arbutus,			
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical	29d. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a anglement stated.	dge, death occurre and/or investigate	ed at the time, date on, in my opinion, c	e and place, and death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	stated to the cause(s)	
F > F 3	Me	29b. Signature and tule of certifier		29c. License i			29d. Date signed		
		30 Name and address of person who completed cause of death (Iten	n 23a)	O.C.M			January 6, 20		
		Mary G. Ripple MD. Deputy Chief Medical Exa	miner 111	Penn Street, I	Baltimore, N	MD 21201			
Si Regis	tate trar	1 A 1 A A	W. Leas	K					

		•	For State Ragistrar	State of Marylar		irtment of H tificate of L			ene 00	7 00168
			Decedent's Name (First, Middle, La	ast)				2. Date of Death		3. Time of Death
	Physici		Jean Abbott	Ault			[-	Month January	Day Ye 7. 2007	21:54 M
	/Medio Examin		4a. Facility Name (If not institution, given			4b. City, Town, or	Location of Death	7	4c. County of [
1			1736 Banbury Ro	oad		Gibson 1	Island		Anne Ar	rundel
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1)	Year) 9.	Birthplace (State or Foreign Country)
	Director		319-20-1250	84	Yrs.			June 21,		lew York
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Aaryli F sho	ō								1 ☐ Yes 2 XNo
	289-	ect	Maryland Anne An	undel Gir	oson Is	10f, Zip Code		100	g. Citizen of Wha	at Country?
	with Be or	₫	1736 Banbury I	Road		21056			USA	,
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13. \	Vas Decedent of Hi	spanic Origin? (Spec	cify Yes or No-	14. Race	American Indian,
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "nature!, or Items 23e or 28e-f show other treamatic event, the Modical Exertiple triaist be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	'	fYes, specify Cuba i □ Yes 2 <mark>]</mark> Ø] No	n, Mexican, Puerto F Specify:	Rican, etc.)	Black, \ Specify:	White, etc. White
21215-0036	2 hou	Completed by	15. Decedent's E		16a. Deced	lent's Usual Occupa	ation	16	6b. Kind of Busin	
715	nin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired,	luring most of workin))g		
212	d with	E	Lientenary/Secondary (0-12)	4	Homem	aker			Own Hom	ne
	e filed Il Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last	t)			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
lar	Aenta Aenta rked tic e	To E	Frank Farnam Abb	oott			Rosamono	l Elizal	oeth Ha	.11
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "I reumatic event, the Med		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	and Number or Rural	Route Number, (City or Town, Sta	ite, Zip Code)
Σ	and 2 saith n 27 i		Jim Ault / Son		5921	Deer Park	Road, Re	eisterst	own, MD	21136
ore	of He of He Fitem	- 17	20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 [1	Place of Dispo cemetery, cren	sition (Name of natory or other place		ate 20	0c. Location · Cit	y or Town, State
Ĕ	Page ment ent: h		4 □ Donation 5 □ Other (Speci		ltop S	ervice Co	orp. 1-9-0)7 To	owson, M	aryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tre once.		21. Signature of Funeral Service Lice	onsee	33 1	Name and Address CCOMAS FU	ineral Hon	e, P.A.	don Mar	yland 21009
			23a. Part1. Enter the disease, or con	nplications that caus the deal						Approximate
	Dharistan		shock, or han failure. List only Immediate Cause (Final	one cause on each me.	0+	1	1			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Pur to (or as a consor	Con Cie	Wrest	Cance,			
	Examiner			Due to (or as a consec	juence or):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	juence of):					
WS	ited insit	Examin	Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events							
	executed n and ial-transit	Exa	resulting in death) Last	Due to (or as a consec	uence of):					
8760,	cia Dur	dlcal	d							
89	ificate g physi as the l	edi								
Вох	The law requires that the death certifi ite has been signed by the attending i page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Il death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
0	the car	hys	9 Unknown	9□ Unknown						
0.	res that igned to be det	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?
rds	anline on sig	g p			_			1 🗆 Yes	22 No 3[☐ Probably 4 ☐Unknown
Records,	w requires been si	Completed						24a. Was an		re autopsy findings available
Re	he la e has age 2	E C						autopsy	ed? dea	
Vital		O	25. Was case referred to medical	T			26. Place of Death			Yes 2 No
>	Physicien: this certific ral director,	o B	examiner? 1 ☐ Yes 2♣No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe				Specify)
o	g Phys er this eral dii	L:u	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at 2	8d. Describe how		вроону)
Division	Attending F r death. ector: Atter by the funera	atlo	1∠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 Y	r? Yes 2 ∐ No			
Vis	Attendia r death. sctor: A by the fu	ifica	3 Suicide 6 Could not I	286. Place of injury · At n	ome, farm, str	eet, factory, office	2	8f. Location (Stre	et and Number of	or Rural Route Number,
Ö	el or s afte il Dir	Certification:	4 Honticide	building, etc. (Special	<i>'Y)</i>			City or Town,	Siale)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) Certifying P	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and manne e and place, and	or as stated. due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	100	1	29c. License	number	290	d. Date signed (A	Month, Day, Year)
			// June	I Wak			5115	/) anuar	18,2007
	16		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	of Mis	ve Of	3 Rusai	nd 1.106/
	Sta	te	61. Date filed (Month, Day, Year)	32 Registrar's Signa	ature		-	, , , ,		3
	Registi	ar	JAN 0 9 2	007 Silver -	A STA	182)				
			VIII TO THE TOTAL THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TOT	1	35					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 8,2007 2:10 a M Jan. Lillian L. Anzmann '/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Lutheran Village 8. Date of Birth June (State or Formula) 9. Birthplace (State or Formula) 9. Birthplace (State or Formula) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1□ M 2□F 95 214-12-4897 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No Funeral Director Md. Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 St. Luke Circle 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Housewife</u> Homemaker 1.2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Lindsey 2 Edward Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Fox Meadow Garth, Westminster, Md.21157 Mark Anzmann - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Woodlawn Cem. Jan. 1 N Burial 2 □ Cremation 3 □ Removal from State 11,2007 Woodlawn, Md. 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Licens 22. Name and Address of Facility P.A.owings Mills cle Eckhardt Funeral Chapel, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonus **Physician** hronic di seas resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ G/allwma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 5 1 7 0 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier punsitia MD 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) DR, Westminster MD 21157 PANSURIPA 349 Malwim 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:15PM 2007 Bert /Medical January 4a. Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITA 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days 1 □ M 2 X F Months Director . 05.2007 Maryland None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Columbia Howard County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3rchard by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Black Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) UNKnown 18. Mother's Name (First, Middle, Maiden Surname) Be Bert - Hall Denise MI. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Rd. Mollie E. Bert Grandmother 20a. Method of Disposition Date. 20c. Location - City or Town, State 1 ♥ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01.10.2007 Woodlawn, 22. Name and Address of Facility Vaughn C. Greene Juneral 21. Signature of Funeral Service Licenses Bervice berty Road aughn (handall stain 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 weeks treme FR ematurit /Medical Due to (or as a consequence of) **Examiner** horio amnionito Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit upture of Membranes reterm -matune and Due to (or as a consequence of) Records, P.O. Box 68760. physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes Division or Vital 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

600

Wolee

address of person who completed cause of death (Item 23a) (Type, Print)

0

1Mguis-32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Bert-Hall brauden 2007 anuer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hop Kins Jehns tospital 8. Date of Birth Birthplace (State or Foreign Country) 7. Age An yrs. last birthday) 5. Social Security Number **Funeral** 1**X**M 2□F Months Days Hours Director None
Usual Residence of Decedent Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 □Yes 2 No Director Olumbio ward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Orchard Drive Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify ş 3 Widowed 4 Divorced 21ack Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) Un Known 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Ber Brompton Road Baltimore MD Mollic Grandmother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 31.10.2007 Woodlawn. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Puneral Service Mandallstain mD 21133 Vaughn C. Steam 8728 Liberty hoad, handall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Extreme /Medical Due to (or as a consequence of): **Examiner** horio amnioni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 ☐ Yes 275 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No To the Funeral Director: After this certificate has autopsy perform To the Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

State

31. Date filed (Month, Day, JAN 0 9 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

07-00119		Please Type or Print in Black Ind			le.
Earl Edward Brov		- For State Certif	tment of Health and Mental Hy ificate of Death	giene Reg N	2007 00172
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		2 Date of Death Month Da	y Year October
Medical Examin		EARL EDWARD BROWN 4a. Facility Name (if not institution, give street and number)	4b City, Town, or Location of Death	January 5, 20	4c. County of Death
		1440 Maple Avenue	Essex		Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min		M/DD/YYYY) 9. Birthplace (State or Foreign
Director		220-72-3984 1XM 2 F 49	Yrs.	11/16/	1957 Country) Md
/any	f		own or Location		10d Inside City Limits
land -f show	ğ	Md Baltimore Ess		140-	1X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filted within 72 hours after death with the Maryland tent of Health and Mental Hygiene unt. If fiten 27 is marked other than "natural", or items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code 21221		Citizen of What Country?
with th ns 23a be noti	ral	1440 Maple Avenue 11. Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian, Black.
r death or iten must l	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	White, etc.
irs after ural", miner	ŝ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 17. Decedent's Education (Specify only highest grade completed)	1 Yes 2X No specify 16a. Decedent's Usual Occupation (Give kind of w	ork done 16	Specify. Black b. Kind of Business/Industry
72 hou n "nat	letec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life DO NOT use retire		
215-0036 be filed within 7 rual Hygiene sked other tham ent, the Medica	ompleted	12 17 Father's Name (First, Middle, Last)	Builder	(First, Middle, Maid	Construction
215-1 e filed tal Hyg sed oth	BeC	Robert Lee Brown		Lee Rou	
21, nould b nd Men is marl rtic eve		19a Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R		
MD 2 sho salth and 2 sem 27 is raumati		Carolyn Brown 20a. Method of Disposition 20b. Pl.	1440 Maple Avenue,		d. 21221 lc. Location - City or Town, State
Ore, ges la t of He I file		1 XBurial 2 Cremation 3 Removal from State	ematory or other place)		
		4 Denation 5 Other Specify: Mt. 21 Signature of Funeral Service Licensing	Name and Address of Facility		
Balt permit Depart Import injury		Tuorne 1. Walle	Step Brothers 1300 Fut aw Plac on higheriter the mode of dying, such as cardiac or	Funeral e Balt	Service
Physician /Medical		failure. I let only one cause on each line.	//	respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Juse (Final disease or condition resulting in death) a. Atherosclerotic C Due to (or as a consequence of):	miliovascular disease		Deatri
\/·		Sequentially list conditions, b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause consequence of):			
pa pa	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi		X UNPENDED AMENDED #230 DTT 2	7 ME 000 1/17/07 IIII		
760, cate be physici he buri	Physician/Medical	IF FEMALE: 23c If yes, outcome of pregna	7, perME, g863, 1/17/07 TT	Ţ	23d. Date of delivery
Box 68760, e death certificate be the attending physic of for use as the burner of for use as the burner of the purpose of the purpose of the purpose of the purpose of the purpose of the purpose of the purpose of the purp	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregnal th 5 Other (Specify)	ncy	Month Day Year
Box e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown	- Silot (-py)		
i, P.O.	by P	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.		co use contribute to the cause of death? No 3 Probably 4 Unknown
ds, Fequires		Diabetes mellitus		24a Was an	24b Were autopsy findings available
tal Records rian: The law requir certificate has been : ector, page 2 should	Completed			autopsy	
I Re n: The rtificate or, pag		25. Was case referred to medical	26.Place of Death (Check of	only one)	No 1 ✓ Yes 2 No
Vital P hysician: this certifi I director,	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 E	ER/Outpatient 3 DOA Other Nursing	g Home 5 Res	sidence 6 🗸 Other: Scene
Division of Vital Records, rai or Attending Physician: The law require aster death. Tal Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be	L :uo	1 V Noture (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d Describe how	injury occurred
livision I or Attend after death. Director:	icati	2 Accident Investigation 28e Place of Injury - At hor		28f Location (Street	et and Number or Rural Route Number, City
DIV pital or ours afte rerat Diu	Certification:	3 Suicide 6 Could not be determined (Specify)	, , , , , , , , , , , , , , , , , , , ,	or Town, State	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici.		29a Certifier 1 Certifying Physician: To the best of my knowledge			
To the within To the	Medical	one) Medical Examiner: On the basis of examination an and manner stated 29b Agnature and title of defitier	id/or investigation, in my opinion, death occurred a		place, and due to the cause(s) Od. Date signed (Month, Day, Year)
- d	2	200 biginating and title of pertiner	O.C.M.E.	1	anuary 5, 2007
OKP		3 Name and address of person who completed cause of death (Item 2			
10		Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 212	01	
	tate	31 Date filed (Month, Day, Year) 9 2007 32. Registrar's Signatur	M. March ?		
Regis	uell	July Market De La Contraction of the Contraction of			

07-00156

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Allen Ivan Ballard State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ January 6, 2007 1325 hrs Allen I. Ballard Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 1625 Cypress Street, Apt. 4 n/a If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Davs Hours Min 219-26-4076 Months Director 68 Country) 2/21/38 MD XX M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A 1 X Yes 2 No MD Baltimore death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number notified at 1625 Cypress Street, Apt 4 21225 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Army 57-6 1 X Yes Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after Divorced If Yes, Give Year Specify: white Widowed ģ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Antique Dealer Sales Baltimore, MD 21215-0036 7 of Health and Mental Hygiene.
If item 27 is marked other the traumatic event, the Med 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linton J. Ballard Freda Whitenfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin G. Ballard / Brother 19 Old Farm Lane, New Freedom PA 17349 Department of Health a Important: If item 2' injury or other traum 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State Burial 2 Glen Haven Cemetery 1/10/2007 Baltimore MD Donation 5 X X Other Specify Entombment 22. Name and Address of Facility
Charles L. Stevens Funeral
1501 East Fort Avenue, Bal 21. Signature of Funeral Service Licensee Victor Doda complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart on each line. Approximate Interval Part I. Enter the disease, or Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical attending physician for use as the burial -UNPENDED AMENDED certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. \$ Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 V No Yes 2 No Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other examiner? Hospital: ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 this ၉ 1 🗸 Yes 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pendina the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hours a determined Δ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 7, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registra

			For State Registrar	tate of Ma	ryland		artment of F		and Me		iene) eg. No.	007	00174
	Physici	an	1. Decedent's Name (First, Middle, Last) Georgie Newman E	Byington					2	Date of Deal Month 01/04		7 Year	3. Time of Death 3:15 a M
)	/Medio Examin	9000	4a. Facility Name (If not institution, give street Kline Hospice House	et and number)			4b. City, Town, o		of Death		4c. Co	unty of Death Freder	
	Funeral Director		230-26-9016		(In yrs. 18 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min	Date of Birth (Month, Day) 07/30/1	Year) 1917	9. Birthp Coul	place (State or Foreign ntry) VA
Ako	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo							10d. Inside City Limits
	he Mar 8a-f et	ector	SC Orangebur	g			Orange	burg			On Citimor	of What Cou	1X Yes 2 No
	3a or 2	al Dir	10e. Street and Number 1467 Rhoad St	reet N.	E.		10f. Zip Code 2	9117		'	og. Citizer	USA	ntry !
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show sort injury or other traumatic event, the Medical Exam har must be notified at QBGs.	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 € No			Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					Race - Americ Black, White, becify: White	etc.
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade co	on Impleted)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during mos	t of working	,	16b. Kind	of Business/In	ndustry
212	d withir giene. er than	omo	Elementary/Secondary (0-12)	College (1-4or 5+	+)		taurant	Oper	ator			Food Se	ervice
Maryland	uld be file Mental Hy irked othe	To Be C	17. Father's Name (First, Middle, Last) George Patton Ne	ewman				18. Mothe	r's Name (Lau:	First, Middle, I ra Ros		mame)	
, Mar,	ind 2 sho alth and 1 127 le ma er trauma		19a. Informant's Name/Relationship (Type, June Bloom / Daughte			19b. Mailir 1313	ng Address (Street 2 Penn S	and Numbe hop Re	oad,	Route Number Mount 2	City or To	MD 21	771
Baltimore,	Pages 1 and the properties of		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☆ Rem 4 □ Donation 5 □ Other (Specify)	oval from State		amatanı crar	sition (Name of natory or other pla rial Gar	dens	Da 1/8/2			ion - City or To ington	own, State Gap, VA
Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Licensee Dorot	a W. Ma:	rsha		. Name and Addre Charles 1501 Fas			Funera	al Hom	me Inc. ore, M	21230
1	Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart faiture. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each line	A	n. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory arr			Approximate Interval Between Onset and Death
,109	ate be executed hysicien and the burial-transit	cal Examiner	Sequentially list punditures if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	brav consequ	PN In face to	m							
.O. Box 68	death certific e attending p d for use as l	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of 1 Live birth 24 Pregnant at t	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			230	Date of deliv	ery Day Year
0_	signed be de	by	Part II. Other significant conditions contrib	uting to death bu	t not resu	ulting in the u	nderlying cause gr	ven in Part I			bacco use es 2 🗆 N		he cause of death? bably 4 Onknown
I Records,		Completed								24a. Was a autops perform	med?	4b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of 2 No
Vital	Physician: This certificatal director, p	Be	25. Was case referred to medical examiner?	oital:			Ot	205		Check only or			
of	ling After Tuner	ıtlon: To	T Tes 2 ANO	28a. Date of Injun (Month, Day	v	ER/Outpatier 28b. Time of Injury	28c. Inju	ry at	28	e 5 🗌 Reside d. Describe h			fy)
Division	al or Attend after death I Director: d in by the t	ertification:	a Could not be	28e. Place of Inju building, etc.	ry - At ho . (Specify	ome, farm, str	eet, factory, office		28	If. Location (S City or Town		lumber or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Directorpletely filled in b	edical C	29a. Certifier Certifying Physici (Check only one)	an: To the best of On the basis of and manner stat	examinal	wledge, death tion and/or in	n occurred at the ti vestigation, in my	me, date an opinion, dea	id place, an	d due to the c I at the time, d	ause(s) an late and pla	d manner as s ace, and due t	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier/				29c. Licen:	3996				igned (Month,	Day, Year) 4, 2007
	6		30. Name and address of person who comp					<u></u>					
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 9 2007	32 Hogistra	r's Signa	ture							

		1 - For State Registrar	State	of Marylan		artment of		d Mental Hy	ygiene Reg. No.2	007	0017
Physici /Medi		1. Decedent's Name (First, Middle Edward Mitchell	Bloom, S					2. Date of D Month 1/5/0	Day	Year	3. Time of Death
Examir	ner	4a. Facility Name (If not institution 7733 Telegraph	Rd., Lot	18	f	4b. City, Town Sevel If Under 1 Ye			Anne	nty of Death Arun	del
Funeral Director		5. Social Security Number 212-40-3329 Usual Residence of Decedent	6. Sex XX M 2□F	7. Age (In yrs. 61	Yrs.	Months Da		Min. (Month, D	1945		place (State or Foreigntry) yland
death with the Maryland ims 23s or 28s-f ehow if must be notified at	Funeral Director		Arundel		y, Town or Lo						10d. Inside City Limit
with tr	급	10e. Street and Number				10f. Zip Cod			10g. Citizen	of What Cou	intry?
s 23e	ral	7733 Telegraph		18 cedent Ever in U.	C 12	2114		/Caseity Vac or N	USA	Race - Ameri	ioan Indian
72 hours after d natural, or itam olcal Examiner	by Fun	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed F	orces? 2 ∰No iive		If Yes, specify 0		? (Specify Yes or Nuerto Rican, etc.)		Black, White	, etc.
within 72 ho ene. than "natur ne Medical I	Completed by		nt's Education est grade completed) (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most of	working	16b. Kind of	f Business/Ir	ndustry
Hygier Hygier Sther th	Cor	7th			Head	Mechan:				lower	
d off	Be	17. Father's Name (First, Middle,						Name (First, Middl			
should and Men amarke umatic	2	Raymond Dewitt 19a. Informant's Name/Relations			10h Mailie	an Address /Str		ed Lorett Rural Route Num.			n Code)
s 1 and 2 f Health a item 27 is		Edward M. Bloom 20a. Method of Disposition	, Jr./Son	20b. P	914 I		est Drive	Be <u>lmon</u> Date		34711	
Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	-		Park 1/1	0/07	Elkrid	lore. M	D
permit. Page Depertment o Important: If eny injury or		21. Signature of Juneral Se w	1		22	2. Name and Ad	dress of Facility	morel He	A M	ID Too	~
hysician /Medical		26a. Parl 1. Enter the disease of Shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	on plications that only one cause on	caused the death	h. Do not eni	or the mode of	tying, such as card	accti	arrest,		Approximate Interval Between Onset and Death
who be executed any project of the purial-transit and the purial-tra	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a conseq (or as a conseq (or as a conseq	uence of):	VS100	ELLYT J ENDLEG		492]	I,	
e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregna Other (specify				Date of deliv Month	rery Day Year		
rithis certificate has been signed by the rail director, page 2 should be detached.	þ	Part II. Other significant conditi	ens contributing to	death but not res	ulting in the u	nderlying cause	given in Part I.		tobacco use co		the cause of death?
rate has been page 2 sho	Completed	30223							opsy formed?	prior to co death?	opsy findings availal ompletion of cause of 2 No
Sertifi	Be	25. Was case referred to medica examiner?	Hospital:					Death (Check only	one)		
to the flowers of Atlanting Priyacters, the factor within 24 hours elife force. After this certificate has completely filled in by the funeral director, page 2.	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investi	28a. Date	Inpatient 2 e of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. li	Other: 4 Nursin	g Home 5 Res 28d. Describe	sidence 6 🗆 0 how injury occ		fy)
s efter des si Directo ed in by th	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 288. Plac	e of Injury - At ho ding, etc. (Specify	ome, farm, str	reet, factory, offi	се		(Street and Nu own, State)	mber or Rur	al Route Number,
tne nospi bin 24 hour the Funari ipletely filk	edical	(Check only	- N	e best of my kno basis of examina nner stated.	wledge, death tion and/or in	vestigation, in m	y opinion, death o	ace, and due to the ccurred at the time	, date and plac	e, and due t	to the cause(s)
L of E	Σ	29b. Signature and title of certifie	188			29c. Lic	ense number		29d. Date sig	ned (Month,	Day, Year)
1		P (X Y	n		0	2545	56	01,	109	1500+
Sta	ate_	30. Name and address of person STSP 1-1-00 Q 31. Date filed (Month, Day, Year,	- 122/Y	Registrar's Signa	2575 iture	DITO	।सि डाक्ष	Starty	GLEN	BUR	S mpo
Regist		JAN 0	9 2007	allegered s	OF A	mell					2106

		•	For State Registrar	State of Maryla		artment of F			ene	07	001	76
	1014		Decedent's Name (First, Middle, La	st)				2. Date of Death	1		3. Time of	f Death
Ŋ,	Physici		Ida	Penn	Barne	S		Month Q1	03	Year 07	1756	P M
	/Medic Examin		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death		
			Holy Cross Hosp	tal		Silver S	pring		Mont	gomer	v	
×	Funeral		Social Security Number 6. 9		s. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State	or Foreign
н	Director		224-30-0352	1□M 2⊠F 82	Yrs.	Monano Bayo	Tiouro Inni.	02-16-1			ginia	
	w		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				1	0d. Inside C	ity Limite
	Aaryla f sho ed at	ō	,									2 □ No
	the N 28a-	Director	DC 10e. Street and Number	W	ashingt	10f. Zip Code		10	g. Citizen of	What Cour	ntry?	
	y with		5000 Et Totton	Owies NE A-+	207	2001	1		USA		,	
	ms 2:	Funeral	5000 Ft Totten 1	12. Was Decedent Ever in		Was Decedent of H		ecify Yes or No-		ce - Americ	an Indian,	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☑ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cubi 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	Rican, etc.)	Specif	ck, White, $_{y}$: $\mathrm{B}1$		
21215-0036	2 hou latura Ical E	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	. 1	6b. Kind of B	usiness/In	dustry	
215	thin 7 e. an "n Medi	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)		Walter	Reed	1	
2	yd wit	Son	12	4		Nu	rse		Hospit			
g	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	aiden Surnar	ne)		
₹	Men Men arke	ို	Edward Barnes					Wilkers				
Maryland	2 sh n and ls m raum	-	19a. Informant's Name/Relationship			ng Address (Street					Code)	
e,	1 and Health		Vicki Barnes / 1 20a. Method of Disposition	Viece Ison		Bradford					901	
Baltimore,	ages nt of l		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre. Brvant	matory or other place Baptist	ce)		Oc. Location	•	,	
	it. Pe intme intant injury	1	4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	y)	Church	2. Name and Addre	0.1-0	9-07 C Engram Fu	Courtla		Virgin	ia
g	Depa Impo any I	8 Z	Sturus. L	oddell		21451 N.		0			337	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	Respirato	ry Fail	ure					Onset and Days	Death
	/Medical	П	resulting in death)	Due to (or as a conse								
	Examiner		Sequentially list conditions,	b. Pneumonia							Days	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):							
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):							
8/60	ficate be executed physician and s the burial-transit	dical E		_d								
9	rtificate ng phys as the	a										
C. Box	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	1			ite of delive onth	-	Year
ري ح	requires that een signed b nould be deta		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use conf	tribute to th	e cause of c	leath?
ğ	quire en sig uld b	ed b	Dehydration					1 ☐ Yes	2 □ No	3 ☐ Prob	ably 4Ⅹ\	Jnknown
Hecords,	law re as bee	Completed by	Dementia					24a. Was an	24b.	Were auto	psy findings npletion of c	available
ř	The I	mo.						autopsy performe 1□ Yes 22	ed?	prior to coi death? 1 □ Yes		ause of
VITal	ian: ertifica etor, I	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		100	20110	
- -	hysic his ce I dire	10	1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Residen	ice 6 🗆 Oth	ner (Specif	1)	
_	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur Worl	y at k?	28d. Describe how	v injury occur	red		
Sign	tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No					
UIVISION	after d after d I Direct d in by	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Num	nber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) 1 ★ CertifyIng Ph	ysician: To the best of my ki niner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and mate and place,	anner as st and due to	ated. the cause(s	s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	e number	290	d. Date signe	d (Month,	Day, Year)	
	9		1 Ha	Mp		D-32	332	0	1-03-0	7		
3	3 1		30. Name and address of person who			,						
			S.K. Gupta, MD	9801 Georg	ia Aver	nue, Suit	e 220, Si	lver Spr	ing, M	D 20	902	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 9 2	32. Registrar's Sig	A A	and I						
	3,011		טאוזי ט	A MICHAEL MARCH	-							

Donald Wayne Banrum State of Maryland / Department of Health and Mental Hygiene Certificate of Death Physician/ Medical Examiner Donald Wayne Bartrum 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital Scounty Number 5. Social Security Number 2. Date of Death Month Day January 1, 2007 4b. City, Town, or Location of Death Shady Grove Adventist Hospital 5. Social Security Number 2. Date of Death Month Day January 1, 2007 4c. County of Death Montgomery 5. Social Security Number 2. Social Security Number Shady Grove Adventist Hospital 5. Social Security Number 2. Date of Death Month Day January 1, 2007 4c. County of Death Montgomery 4c. County of Death Montgomery 5. Social Security Number 2. Social Security Number January 1, 2007 4c. County of Death Montgomery	-
Physician/ Medical Examiner Donald Wayne Bartrum 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number Director Social Security Number 2. Date of Death Month Day Year 1737 hrs 4b. City, Town, or Location of Death Gaithersburg 4c. County of Death Montgomery 4d. County of Death Montgomery 4c. County of Death Montgomery 4d. County of Death Montgomery 4d. County of Death Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Director 7. Age (In yrs. last birthday) The Month Day Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min.	-
Donald Wayne Bartrum 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number 230-37-3708 1X M 2 F 34b. City, Town, or Location of Death Gaithersburg 4b. City, Town, or Location of Death Gaithersburg 4c. County of Death Montgomery 4d. County of Death Montgomery 4c. County of Death Montgomery	-
4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number 230-37-3708 1X M 2 F 34 Yrs. 4b. City, Town, or Location of Death Gaithersburg 4c. County of Death Montgomery 9. Birthplace (State of Foreign Country) Virgonic Country) 1X M 2 F 34 Yrs.	
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 34 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 34 Yrs. 6. Sex 1 X M 2 F 34 Yrs. 7. Age (In yrs. last birthday) 1 X M 2 F 34 Yrs. 7. Age (In yrs. last birthday) 1 X M 2 F 34 Yrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 1 X M 2 F 1	
Director 230-37-3708 1X M 2 F 34 Yrs. Months Days Hours Min. 01/14/1972 Foreign Country) Virg	
230-37-3708 1X M 2 F 34 Yrs. 01/14/1972 Country) Virg	
	zinia
Usual Residence of Decedent	,
10a. State 10b. County 10c. City, Town or Location 10d Inside City	y Limits
The second secon	X No
10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country?	
VA Prince William Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7800 Tayloe Drive 20112 U.S.A	
7800 Tayloe Drive 20112 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Blace)	k,
To be a second of the specific Control of the specific	
1 Yes 2 No Specify: Specify white	
Specify hite 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry	
during most of working life DO NOT use retired)	
15. Decedent's Education (Specify only highest grade completed) 16. Rind of Business/Industry	
18. Mother's Name (First, Middle, Last)	
Properties and the state of the	
To place the second of the sec	
VA Prince William Manassas 10f. Zlp Code 10g. Clitzen of What Country?	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)	
Solution 1 X Burial 2 Cremation 3 Removal from State Crematory or other place)	
Marshall Cemetery 1-5-07 Marshall, Virgini 22 Name and Address of Facility	a
Pierce-Price Funeral Home	
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat Approximate	Interval
Medical failure. List only one cause on each line Between Ons	set and
Examiner Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	_
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of);	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of):	
e and and and and and and and and and and	
AMENDED #23a,27,28a-f, perME, g863, 1/22/07 TT	
23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery	
So the second pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Ye Pregnant at time of death 5 Other (Specify)	ear
AMENDED #23a,27,28a-f, perME, g863, 1/22/07 TT FEMALE: 23c. If yes, outcome of pregnancy 1	
AMENDED #23a,27,28a-f, perME, g863, 1/22/07 TT Variable Varia	ath?
O' te standing of the standin	
The part II. Other significant conditions of death but not resulting in the underlying cause given in Part I. AMENDED #23a,27,28a-f, perME, g863, 1/22/07 TT 23d. Date of delivery Month Day Yes possible and provided the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23d. Date of delivery Month Day Yes 2 No 3 Probably 4 Vunknown 23d. Date of delivery Month Day Yes 2 No 3 Probably 4 Vunknown 23d. Date of delivery Month Day Yes 2 No 3 Probably 4 Vunknown 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Was an 124b. Were autopsy findings at 24d. Were autopsy findi	vailable

29d Date signed (Month, Day, Year)

January 2, 2007

Division of Vital Recor

Compli autopsy performed? prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death To the Funeral Director. After this certificate has leompletely filled in by the funeral director, page 2 si After this certificate has funeral director, page 2 sl death? ✔ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital. 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other Scene Medical Certification: To 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Natural Yes 2 X No Pendina Fnd 1/1/2007 Fnd 4:30 pm unknown 2 Investigation Accident 28f. Location (Street and Number of Rusal Route Number City or Town, State) 409 Middy Branch #102 Gaithersburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined (Specify) Homicide House 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

31. Date filed (Month, Day, Year) JAN 0 State Registrar

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifie

Pamela E. Southall, MD

30. Name and add use of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

		•	1 - For Stete Registrar	State of Mary		artment of Heal rtificate of Dea		ntal Hygiene Reg. No	4UU/	00178
1	*		1. Decedent's Name (First, Middle, Last	")			2.	Date of Death	٧	3. Time of Death
	Physicia		Madge Robbins	Birdsong				Month Da	y Year	1123pm
	/Medic Examin		4a. Facility Name (If not institution, give	3		4b. City, Town, or Loca	ation of Death	40	. County of Death	
	LAdiniii	٠. ن	Carroll Hospital	Center		Westminste	r		Carroll	
	Funeral		5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs. 8.	Date of Birth	9 Birthn	lace (State or Foreign
	Director		239-26-4382	☐M 21X1F	33 Yrs.	Months Days Ho	ours Min. 4	(Month, Day, Year) -25-1923	North	Carolina
New	Maryer.		Usual Residence of Decedent							
	ylan		10a. State 10b. County	10	c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Mar.	ţo	Maryland Carroll	1	Westminst	er				1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10g. Cit	tizen of What Coun	itry?
	3a o		450 R. Union Town	Вd		21158		USA		
	72 hours after death with the Maryland natural; or iteme 23a or 28a-f show licel Exant ner must be rodilled at	Funerai	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify		14. Race - Americ	an Indian,
10	r Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No				an, etc.)	Black, White,	etc.
33	urs a	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√∑ No Sp	ecify:		Specify: Whi	t o
ŏ	2 hou		15. Decedent's Edu		16a. Dece	dent's Usual Occupation		16b. K	ind of Business/Ind	
15	n"n	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done during DO NOT use retired)	most of working			
21215-0036	J within 72 hours after death with the Marylan jiene Han "natural", or iteme 23a or 28a-f show tre Medical Evanter med the rolitied at	Completed	12	College (1-401 5+)	Homen	naker	. *	Own	n Home	
D	illed Hygi other	Bec	17. Father's Name (First, Middle, Last)			18. 1	Mother's Name (F	irst, Middle, Maiden	Sumame)	
Maryland	should be nd Mental marked o	To B	Randolph Robbins			A1	ice	Chinnis		
2	2 should and Men le marke aumatic	-	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	ng Address (Street and N		oute Number, City o	or Town, State, Zip	Code)
Š	Ith a		Olivia Martin- da	aughter	450 F	R. Union Tow	m Rd W	estminste	er. MD 21	158
Ġ,	s 1 and 2 should be filed if Health and Mental Hyg item 27 le marked othe other traumatic event,		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Date	The state of the s	ocation - City or To	
<u></u>	nt of nt of t: If it		Manual 2 ☐ Cremation 3 ☐			matory or other place)			- 233	
臣	rtme rtani njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	-27		e Memorial Parl 2. Name and Address of F		O7 E1k	ridge, M	D
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot			,	Ga	rv L. Kaufm	an Funer	al Home a	at MMP, I	NC.
	10 July 12 1		23a. Parti Enter the disease, or comp	NI	72	250 Washingt	on Blvd.	, Elkridg	je, MD 21	075 Approximate
н			SHOCK, OF HEAR FAILURE. LIST OFFING	nie Cause On each mie.						Interval Between Onset and Death
1.12	Physician		Immediate Cause (Final disease or condition	CLOSTR	Dium	DIFFICI	LE C	コレート	>	
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
	Lxamilici		Sequentially list conditions.	b						
	D 15	Examine	if any, leading to immediate cause. Enter Undertying	Due to (or as a co	onsequence of):					
	and tran	ше	Cause (Disease or injury that initiated events resulting in death) Last	c						
90,	icate be executed physicien and s the burial-transit	Ē		Due to (or as a co	onsequence on);					
68760,	ate b hysic the b	edicai		d						
-		Med	IF FEMALE:			-				
Box	leath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outcome of p □ Live birth 2		Ectopic pregnancy			23d. Date of delive Month	ery Day Year
-	e dea he al	sic	in the past 12 months? 1 Yes 2 No	4☐Pregnant at tim 9☐ Unknown	e of death 5[Other (specify)			WIGHT	Day real
P.0	The law requires that the death certi tle has been signed by the attending age 2 should be detached for use a	Physician/M	9 □ Unknown `							
	gned be de	by I	Part II. Other significant conditions co				Part I.		use contribute to th	
of Vital Records,	w require been si should t		officer c	NO VIL	777			1 🗆 Yes 2	No 3□ Prob	eably 4 Unknown
S S	aw reas be	ompieted						24a. Was an	24b. Were auto	psy findings available mpletion of cause of
ď	sician: The lav certificate has irector, page 2	E						autopsy performed? 1 ☐ Yes 2 No	death?	
ta		C	25. Was case referred to medical			26.	Place of Death (C		,	
>	Physician: rthis certificant	O B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Appatient	2 ER/Outpatie			5 Residence	6 ∏Other (Specifi	v)
<u>6</u>	g Phys er this eral di	E I	27. Manner of Death	28a. Date of Injury	28b. Time o			. Describe how inju		,
Division	or Attending F ifter death. Director: After in by the funer.	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	M 1 Yes	2 No			
/is	al or Attendii after death. I Director: A d in by the fu	itici	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury		reet, factory, office	281.	Location (Street ar		l Route Number,
ā	al or afte i Dir	Certification:	4 Homicide	building, etc. (\$	Sресіту)			City or Town, State	9)	
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Phy	sician: To the best of m	ny knowledge, deat	h occurred at the time, da	ate and place, and	due to the cause(s) and manner as st	ated.
	P Hc	edicai	(Check only 2 Medical Exeminate)	iner: On the basis of ex- and manner stated	amination and/or in	vestigation, in my opinion	n, death occurred a	at the time, date and	d place, and due to	the cause(s)
	To th	₩.	29b. Signature and title of certifier			29c. License num		29d. Da	te signed (Month,	Day, Year)
	0		draw	2 GE		D 303	263	I.	-4-07	r
_	/ \		30. Name and address of person who co	ompleted cause of death	h (Item 23a) (Tyna	Print)				
- 1	\mathcal{C}		30. Name and address of person who compared to the second	HOO, MD	200	MEMORIA	L AVE	21157		
-				1-1	w	ESTANISTS	CO MD			
160	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND THE TOP PET IN . (303) 1/20/07 WS

State of Maryland / Department of Health and Mental Hygien? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 01 05 Braswell 07 Mamie 7:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Adelphi House Hyattsville P.G. 8. Date of Birth (Month, Day, Year) Apr. 26, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 1 F 238-28-7823 1920 North Carolina 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 Rambler Place 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Beautician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ivory Bryant Jennie Bynum 19b. Mailin **(Traigs Su**eet and Number or Rural Route Number, City or Town, State, Zip Code) 441 Chantilly Park Dr. Reisterstown MD. 21136 19a. Informant's Name/Relationship (Type, Print) Richard Braswell/grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1-12-2007 Pinelawn Cemetery Farmingdale, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, V.C. 20011 marsk 23a. Payl. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Atherosclerotic Cardiovascular Disease years Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown <u>Dementia (Severe)</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Assisted Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) Living1 ☐ Yes 2√∑ No 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 2 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

The law requires that the death certificate be executed physicien and the burial-transit P.O. Box 68760. as the attending use ó detached ģ signed t Division of Vital Records, page 2 should be this certificete has been or Attending Physician: filled in by the funeral director, After death. within 24 hours after deat To the Funeral Director: the Hospital

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

ပ

Physician/Medical Examiner

2

Completed

Be

TOF

Certification:

Medicai

29b. Signature and title of certifier

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If Item 27 ie marked other than "natural", or Iteme 23s or 28s-f ehow

Baltimore, Maryland 21215-0036

tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examples must be motified at

5

permit. Page Department c Important: If any injury or once.

Physician

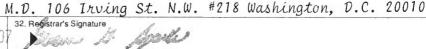
/Medical

Examiner

State Registrar

Dr. Raj P. MAthur, 31. Date filed (Month, Day, Year) JAN 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D42403

29d. Date signed (Month, Day, Year)

1/8/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician January 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathinore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NEC. 13 Baltimore 3842 Boaman Avenue 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 6. Sex **Funeral** Year 1 M 2 SF 212-40-1943 SOUTH CAROLINA Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 ☐ Yes 25 No 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 ho Department of Health and Menial Hygiene. Important: if item 27 ie marked other than "natur mortant: if item 27 ie marked other than "natur injury or other traumatic event, the Madical and and 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OMESTIC PRIVATE THGRADE WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Peges 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 01-11-07 BALTIMORE MARYLAND

22. Name and Address of Facility 2140 North Fulton Avenue MD 21217 21. Signature of Funeral Service Licensee Joseph H. Brown, Vr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a ATHEROSCLEROTIC CARDIOVASCULAR Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) anding physicien end use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? DemonTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 030272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

MAIDEN

MILLEN 744

32. Registrar's Signature

CHOICE LANE SUITE ZOY BALTIMORE, MID

			1 - For State Registrar	State of Mary		artment of H			giene 20 (7	00181
	Physici		1. Decedent's Name (First, Middle, Last)	+ BI	ARNE.	5		2. Date of Dea Month	Day	Year	3. Time of Death 7:57PM
)	/Medic Examin		4a. Facility Name (If not institution, give s MERCY MEDI	treet and number)	NTER	4b. City, Town, or	Location of De	ath	4c. County o	f Death	RE CITY
	Funeral Director		5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birt	h v, Year)		ace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation		7007217			d. Inside City Limits
	e Mary	ctor	MD BALTIMO	RE	GW	YNN OAK					1 ☐ Yes 2 🙀 No
	with the	Funeral Director	10e. Street and Number 3501 MAYFAIR ROX	V D		10f. Zip Code	1 2 2 7		10g. Citizen of Wi	nat Count	ry?
	death	nera		Was Decedent Eve Armed Forces?	r in U.S. 13. V		1207	(Specify Yes or No-			
036	s 1 and 2 should be filed within 72 hours efter death with the Maryland of Heelih and Mental Hygiene. It Heelih and Mental Hygiene. Item 27 is marked at Hygiene. Other traumatic event, the Medical Examinar must be notilied at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 21 No	Specify:	eno rican, etc.)	Specify:	, White, e BLA	
15-0 15-0	"natur	leted	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done d OO NOT use retired,	turing most of w	vorking	16b. Kind of Bus		•
Maryland 21215-0036	filed withir Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		PECTOR			COMPAN	Y	L CAN
and	id be file lenta! Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) WILLIAM E. HOU	JCK				ame (First, Middle, E JONES	Maiden Sumame)	
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a		Rural Route Numbe	r, City or Town, S	tate, Zip (Code)
	Heelth tem 27 other tr		WARREN H. BARNES 20a. Method of Disposition		3501 20b. Place of Dispos	sition (Name of		D, BALTI	MORE, I	1D 2 lity or Tov	1207 vn, State
altimore,	0 0		1 Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	WEST LIE	BERTY U.	M_{\bullet} 01/	/13/07	HARFORI	CO	UNTY, MD
Balt	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service License	8. Noa	NO	EMETERY 500 LIBE		HOWELL F			
Į			23a. Burt: Enter the disease, or complication, r hear failure. List only on time in Cause (Final	0.4			g, such as cardi	ac or respiratory ari	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		dis a for condition resulting in death)	Due to (or as a co	ARDIA	Z IN	FAR	CTION		-	DAYS
	Examiner	_	Sequentially list conditions, b	ATR Due to (or as a co		FIBRI	LLA7	TION			YEARS
W	cuted id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			KION	/EY	DISER	H5E		YEARS
8760,	cate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a co							
. 687	intificate ing phys a as the	Medic	IF FEMALE:								
Вох	death certific attending p	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	Sc. tf yes, outcome of p 1☐Live birth 2☐ 4☐Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti		y Day Year
<u>о</u> .	that the de led by the a detached	Physi	9 Unknown	9□ Unknown							
ds,	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	d by	Part II. Other significant conditions conditions	_	ot resulting in the ur	iderlying cause give	en in Part I.		bacco use contrib es 2□No 3	oute to the	
Vital Records,	faw rec as beer 2 shou	Completed						24a. Was a		ere autop	sy findings available ptetion of cause of
<u>a</u>	hysician: The faw his certificate has t I director, page 2 s	e Con	or W					perfor 1 ☐ Yes	med? de 2020 1	ath?	
<u>=</u>	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	ospitat:	2 ER/Outpatient	3□ DOA Othe		eath Check only or Home 5 - Reside		(Specify)	
0 00			27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	par) 28b. Time of Injury	28c. Injury Work			ow injury occurred		
Division of	To the Hospital or Attending F within 24 hours effect death. To the Funeral Director: After completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - building, etc. (S	At home, farm, stre		2 110	28f. Location (S City or Town	treet and Number n, State)	or Rural	Route Number,
_	To the Hospital within 24 hours e To the Funeral Completely filled		29a. Certifier 1 Certifyin J Phys	ician: To the best of mer: On the basis of exa	y knowledge, death	Jonumed at the time	a, data and plac	es, and due to the e	ause(s) and mans	or as star	lod.
	thin 24 thin 24 the F omplete	Medical	29b. Signature and title of certifier	and manner stated.		29c. License		· · · · · · · · · · · · · · · · · · ·	9d. Date signed (
	F ≱ F 8		14/11/k	IIn	つ.			1	٠, ٠		* '
	12			npleted cause of death		Print)	3/1	Ct om	II PIA	1-	BALTIMORE, AD 21202
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	(WI D	. 501	31 //10	10 101		MD 2/202
	Registr	ar	JAN 0 9 2	007	J. B. A.	2012					

State of Maryland / Department of Health and Mental Hygiene

			otato or maryia	Cen	tificate of	Death		Reg. No.	1	UUI	32
		1. Decedent's Name (First, Middle, Las	1)				2. Dete of Dee		Yeer	3. Time of	Deeth
	Physician /Medical	NIC LODIA	В	IEGALS	<1		Januar			9:10) PM
	Examiner	4e Fecility Neme (If not institution, give				4b. City, Town, or I	Location of Deeth	4c. County	of Deeth		
		St. Joseph's Nurs			KII. 1 - 1 V	Catonsvi If Under 24 Hrs.	lle	Balti	more		
	Funeral	5. Sociel Security Number 6. Se	□M 2XF	s. lest birthdey) Yrs.	If Under 1 Year Months Deys		(Month, De	y, Year)		place (State of ntry)	r Foreign
	Director	215-26-0162 Usuel Residence of Decedent	98	113.			08/07/	1908	Mar	yland_	
	brei M	10a. Stete 10b. County	10c. 0	City, Town or Loc	ation				1	10d. Inside Cit	y Limits
	Mary Historical	 Maryland Baltimor	Cat	onsvill	0					1 ☐ Yes	2 No
	ifter death with the Ma r flows 23a or 28a-1s flore must be notified Funeral Director	10e. Street end Number	C	CITOATTT	10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	h with	1222 Tugwell Driv	·		21228			United	State	26	
	deat deat	11. Maritel Status	12 Was Decedent Ever in	U,S. 13. W		Hispanic Origin? (S ban, Mexican, Puert			ce - Americ	can Indian,	
9	after of the DT		Armed Forces? 1 Yes 2 No If Yes, Give		☐ Yes 2 No			Specif			
9	72 hours after death with the Maryland natural; or tems 23a or 28a-f show alcal Examiner must be notified at steel by Funeral Director	3 Widowed 4 □ Divorced	Year or Dates:						AATIT		
21215-0036	led within 72 hours siygiene. The than "natural", of the Medical Exart. Completed by	15. Decedent's Ed (Specify only highest great		16e. Decede	ent's Usuel Occu	petion during most of wor ed)	rking	16b. Kind of B	usiness/Inc	dustry	
12	within then.	Elementary/Secondary (0-12)	College (1-4or 5+)			1 0)					
d 2	should be filed with nd Mental Hygiene. marked other than umatic event, the To Be Comi	12 17. Father's Neme (First, Middle, Last)		Teach	er	18. Mother's Nan	ne (First, Middle,	Fducat Maiden Surnar			
an	d be fill and H cod out to ever					Victoria			•		
Maryland	should to the marked marked metic e	19a. Informant's Name/Relationship (7	"vpe. Print)	19b. Mailing	Address (Stree	t end Number or Ru		ar, City or Town	, State, Zir.	Code)	
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the profiled at Page. To Be Completed by Funeral Director	Conrad Biegalski		1767	Briđaovi	lew Drive	Пастиа	Washin	otton	99496	
ē,	tem tem	20a. Method of Disposition	20b.	Place of Dispos cemetery, cremi	ition (Name of	ical OTIVE	Date	20c. Location			
9	Page: ento rt: If i	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval Irom State	. Olive			01/08/07	Bladon	chur	Marry	back
Baltimore,	artm ortar inju	21. Signature of Funeral Service Licens	Ivit	22.	Name and Addr	ess of Fecility				I PRILY	Tanc
ä	permit. Depart Import any inj	A. 1119	111			Weber Fund				7 21	220
		23a. Pert1. Enter the dis dee, or comp shock, or heart failth. List only of	olicetions that caused the de			ndson Aver			Maryı	Approximate Interval Bety	
	Physician	shock, or heart fail List only o	one cause on each line.						1	Onset and D	veen)eath
	/Medical	Immediate Cause (Final disease or condition	STRO	KE					1	71.6	EEKS
1	Examiner	resulting in deeth)	0.	(or as e consequ	ience of):				-	× 00	pp (m
,	D E			(5) 51 - 51 - 4							
× l	The law requires that the death certificate be executed ethe has been signed by the attending physicien end page 2 should be detached for use as the bunal-trensit Completed by Physician/Medical Examiner	Sequentially list conditions,	b. Due to	(vi às à consequ	iance off).						
တွ်	de exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•						!		
68760,	ohysic the t	that initiated events resulting in death) Last	Due to	(or as a consequ	ence of):						
	ding I		d								
Вох	eath cer attandir I for use clan/N						1			-	
P.O.	v requires that the death ce been signed by the attandi should be detached for uss sted by Physician/	Part II. Other significant conditions co				ven in Pert I.		obacco use co			
	that hed by deta	ALZITEIT	ners L	EMEN	MA		10,	Yes 20010	3 Pro	bably 4 🗆	Juknomu
of Vital Records,	uiras nid be						24a. Was	an autopsy	24b. W	ere autopsy fi	indings
00	The law require sete has been signed as 2 should Completed						perto	rmed?	co	allable prior to mpletion of ca death?	
Re	he law e has aga 2						101	res 2 No	+	JYes 2□	No
ta	certificate rector, pag	25. Wes case referred to medical				26 Place of Des	ath (Check only o	-	1		
<u>=</u>	Physician: this certific ral director,	exeminer?	Hospitel: 1 Inpatient 2	☐ ER/Outpetient	3 DOA O		lome 5□ Resid		ner (Specif	(v)	
ठ	a Physer this seral of	27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of	28c. Inju		28d. Describe h			,,	
0	ath. r: Afte	2 Accident 5 Pending investigation		Injury		Yes 2□No					
Division	Atte ecto by th	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Num	ber,
	s effer ed in	To the time of time of time of the time of tim	building, old. (Opoc					, 51515,			
	To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, paga Medical Certification: To Be Com	29a. Certifier Certifying Phy	rsician: To the best of my kr)
	the thin 2, the Find 2, the Find 3, the Fi		end menner steted.			se number					
	ot visit	29b. Signature end title of certifier	\sim		29C. Licen	t I () a I)	-	29d. Date signe	DU Z	Day, 1841)	07
•	2	-AUFER			D00	40012		7 14004	-7 -)	
	19	30. Neme end eddress of person who of Scott Pouchon	completed cause of death (Ite	em 23e) (Type, P	RO. S.	HTE DOY	CATO	usur Lie	E, M	0 21	228
		31. Date filed (Month, Day, Year)	32 Registrer's Sign	neture	- 1-	-1 (1		/		
	State Registrar	Dr. Bate med (mem, Bay, rea/	07	H Rose	10 5 T						
DH	MH 16 Rev 6/95		A Company of the second	A STATE OF THE PARTY OF THE PAR		-					
5.1				ORIG	SINAL						

Registrar

_			For State Registrar	State of	Maryland	-	rtment tificate				R	eg. No.	7 00184
	Physici		1. Decedent's Name (First, Middle, Joseph Bosto	•							Date of Dea Month	Day Yes	3. Time of Death 6:36 A.M.
•	/Medio Examir		4a. Fecility Name (If not institution, Baltimore Wash	give street and num		nter	4b. City, To	-			1 - 10(-1.	4c. County of D Anne A	eath
	Funeral Director				7. Age (In yrs. las		If Under 1 Months (If Under 2 Hours	Min.	Date of Birth Month, Day	9.1 8 1916 N	Birthplace (State or Foreign Country) [aryland
	e Maryland 3a-f ehow	ctor	10a. State 10b. County	Arunde1		Town or Loo bril							10d. Inside City Limits 1 ☐ Yes 2√2 No
	death with the ms 23s or 28s	Dire	10e. Street and Number	- 1 1 D 1			10f. Zip C					0g. Citizen of What	Country?
36 J.	2 hours after death with the Marylar atural; or Itema 23a or 28a-f show cal Examinar must be notified at	by Funera	faryland Anne 10e. Street and Number 1187 Summerfi 11. Marital Status 1 Never Married 2 Marrie	12. Was Deced Armed Ford 1 Tyes 1. If Yes, Give	No No					in? (Specify Puerto Rica	Yes or No- n, etc.)	USA 14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
B 05TC	7 0	Completed b	3 XWidowed 4 □ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give I life. E	ent's Usual (kind of work OO NOT use	done dui retired)	ring most	of working		16b. Kind of Busine	ss/Industry
	filed wi Hygien ther th	e Con	7th 17. Father's Name (First, Middle, La	O (st)		Tru	ack D			's Name (Fir		Post Bil Maiden Sumame)	lington
∱ ylan	2 should be and Mental is marked o	To Be	Summerfield I	Boston						iza C			
Mar	id 2 sho ith and 27 is m traum		19a. Informant's Name/Relationship Charles S. Bo									r, City or Town, State	id. 21054
五のSEP中 Baltimore, Maryland	permit. Pages 1 and 2 should be filled within Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than eny injury or other traumatic event, the Monce.		20a. Method of Disposition 1 Burial 2 A Cremation 3 4 Donation 5 Other (Spe	☐Removal from S	20b. Plac	ce of Dispos netery, crem	sition (Name natory or other remat	of er place)		Date -10-0		20c. Location · City Baltimor	or Town, State
Balti	permit. Departinitmports eny inju		21. Signature of Funeral Service Li	Reese Ma	00883							ary, P. <i>A</i>	401
.8760,	Physician /Medical Examiner burial-transit sthe purial-transit	dical Examiner	23a. Part 1. Enter the disease, or content failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	used the death. ch line. or as a conseque or a conseque or a conseque or a conseque or as a conseque or a cons	mce of):	lan lan					ess.	Approximate Interval Between Onset and Death
.O. Box 6	aath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	ome of pregnance th 2 ☐ Fetal de nt at time of dea	eath 3 🗆	Ectopic preg Other (spec					23d. Date of o	delivery Day Year
4	wrequires that the deben signed by the should be detached	à	Part II. Other significant condition	s contributing to dea	ath but not resulti	ing in the un	derlying cau	ise given	in Part I.	_	23e. Did to	✓	to the cause of death? Probably 4 □Unknown
Division of Vital Records,		Completed							-		24a. Was a autops perfori 1 ☐ Yes	y prior t ne≰? death	autopsy findings available o completion of cause of ? es 2 No
Vita	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	patient 2□EF	R/Outpatient	3□ 004	Other		of Death (Ch			
sion of	g age	Η.,	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Dite of (Month		8b. Time of Injury		: Injury a Work?		28d.		ence 6 ⊡Other (S ow injury occurred	респу)
Divis	tai or Attus safter de ai Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At hom g, etc. (Specify)	e, farm, stre	eet, factory, o	office		28f. L	ocation (Si City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hoepital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	one)	Physician: To the taminer: On the base and manner	sis of examination	edge, death n and/or inv	occurred at estigation, in	the time, my opin	, date and nion, death	place, and o occurred at	due to the c the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To t To 1	2	29b. Signature and title of certifier	M	۸.		29c. L	License r	number 977		2	9d. Date signed (Mo	nth, Day, Year)
	5		30. Name and ad re- of person w	no completed cause	of death (Item 2	3a) (Type, F	Print)	<u> </u>	ماره	bana	nie.	C GM	1061
1	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9	32 Ae	gistrar's Signatur	e A	retes	<u> </u>	my	OUN	11/4	175 2	1-0.

Nelsene Burnette 07-00054 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

, ,		 	in oobico tiic Ei
State of M	aryland / Department		

ONIC ONIC		1- For State Registrar 1. Decedent's Name (First, Middle,L	e of Maryland / L	-	ent of Health ar ate of Death	nd iVlenta	, , , , , , , , , , , , , , , , , , ,	eg. N o. 2 (107 0019
Physic Medical Exam		· · · · · · · · · · · · · · · · · · ·	H .		Burn	ette	2. Date of Dea Month	Day Yea	3. Time of Death 1810 hrs
		4a. Facility Name (if not institution, g			4b. City, Town, o		January 2	4c. County o	
		2027 West North Avenue	e Apartment 2		Baltimore				
Funeral		Social Security Number 6.	Sex 7. Age (I	n yrs. last birth	· · · · · · · · · · · · · · · · · · ·			rth(MM/DD/YYYY	9 Birthplace (State or
Director		219-84-1993	M 2X F	14	Yrs. Months Da	ys Hours	Min. 03 3	62	Foreign Country) MD
à		Usual Residence of Decedent 10a. State 10b. County	740	- O:t- T-					
ow any		MD Baltin		Cato	nsville				10d. Inside City Limits 1 Yes 2 X No
Aaryland 28a-f show I at once.	향				10f. Zip Code			0- 04	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number Winters 605 Winders La	ne			1228		0g. Citizen of Wh.	*
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	ᄪ	11. Marital Status	12. Was Decedent Eve	er in U.S	13. Was Decedent of H		7 (Specify Yes or No		American Indian, Black,
death r iter	Funeral	1 Never Married 2 Marrie	Armed Forces?	No	If Yes, specify Cuba			White	etc.
after al", o	by F		ed If Yes, Give Year		1 Yes 2X N	o specify:		Specify.	Black
hours at natural	pe	15. Decedent's Education (Specify			Decedent's Usual Occupa luring most of working life			16b. Kind of Bus	iness/Industry
ان م	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)	1	Sales Cle		- 1 - 1 1 1 2 1	Valve	City
5-00; ed with tygiene other t	l oc	17. Father's Name (First, Middle, Las			Daies Cie		Jame /First Middle I	1	
	Be	Nelson Jackso				Marj	Name (First, Middle, Morie Fow	kes .	Powles Fowlkes
2121 nould be f nd Mental is marked tic event,	ဥ	19a Informant's Name/Relationship			Mailing Address (Stre			nber, City or Town	
and 2 shou lealth and N		Eldora Taylor-	Sister		Sharrow				21244
ore, Nes I and of Health		20a Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	20b. Place of cremato	Disposition (Name of cery or other place)	1	Date	20c. Location - I	City or Town, State
Limo Pagement ment tant: or ot		4 Donation 5 Other Specia	fy:	Wes	tview				ville, Mđ
Baltimore, permit. Pages and Department of Heal Important: If iten injury or other tra		21. Signature 115 neral Service Lice	ensee		22. Name and Address Mass Was b	s of Facility H Wes	t		w. 2
Physician	-4	23a. Part I. Enter the disease, or con	polication that caused the	death Do not	enter the mode of dying	asn A	ve, Balt	imore,	Md 21215
/Medical		failure List only one cause on	each line.			, 5007 05 0010	ide of respiratory arre	est, shock, or fleat	t Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Head and neck Due to (or as a conseque	injurie ence of)	25				Death
		ocquentially list conditions,							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):					
d sit	xan	(Disease or injury trial initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
760, icate be executed physician and the burial - transit			10e	.18 per	r fh o86/c 2	-6-M7 -			
'60, ate be e: physician	Medical		AMENDED #23a,	27,28a-f	perME. g863.	1/11/0	7 TT // #18,	perFH, g86	4, 2/21/07 TT
876 tificat ng ph as the		IF FEMALE: 23b Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	of pregnancy	Fetal death 3	Ectopic pr		23d Date of d Month	elivery Day Year
Box 687, the death certification of the attending part of the death or use as the	Sicie	1 Yes 2 No 9 Unknow	4 Pregnant at time	e of death 5	Other (Specify)		,		Day 100
the de	Physician/	Part II. Other significant conditions	9 Olikilowii	t not rose items	in the second of		00 0	1	
ires that the signed by the detached	ρ	Tartii. Other Significant Conditions	contributing to death bu	t not resulting	in the underlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown
ords, * require s been sig	Completed				<u>-</u> -	<u> </u>			ere autopsy findings available
COF	g E						autops perfor	sy pri	or to completion of cause of ath?
Re r: The tificate or, pag		25. Was case referred to medical			20 Diag	f D th / Oh	1 ✓ Yes 2	2 No 1	Yes 2 No
Division of Vital Records, in or Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	o Be		Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA	Other N		Residence 6	Other Seens
1 of Ning Phy After the	-1	27. Manner of Death	28a. Date of Injury (Month, Day,Year)			ry at Work?		ow injury occurred	
ion tendin eath for: /	igi	Natural 5 Pending 2 Accident Investiga	End 1/2/2000	7 Fnd '	5:55 pm 1=	Yes 2 X No	subject a	hat Iusaa	
ivisior for Attencafter death Director:	ertification:	3 Suicide 6 Could no	28e. Place of Injury		m, street, factory, office t	ouilding, etc.			or Rural Route Number, City North Avenue
Divi	Cer	4 X Homicide determine	(specify apa	rtment			Apt. 2 Ba	<u>lltimore. N</u>	1D
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	29a. Certifier 1 Certifying Physic cone) 2 Medical Examine	cian: To the best of my known: On the basis of examina	owledge, death	h occurred at the time, divestigation, in my opinion	ate and place, n, death occurr	and due to the cause ed at the time, date a	e(s) and manner a	s stated.
To wit To con	Mec	29b Signature and title of certifier	and manner stated.	_	29c Licens				(Month, Day, Year)
_		MIL	x11 010		O.C.	M.E.		January 3, 2	
	}	30. Name and address of person who	completed cause of death	(Item 23a)					
		Melissa Brassell, MD	ssistant Medical Ex	aminer	111 Penn Street, E	Baltimore, N	/ID 21201		
St Regis		31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	1.4.				
DHMH 17 Rev 1/2		JAN 0 9 200	7 Been	D. A					
OCMF 2006	JUI			ORIG	GINAL				

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** harles 12:15 AM Banning 07 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA VA Medical Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUN 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 1932 74 Director 363**-**34-9837 Michigan Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Inpeartment of Health and Mental Hygiene. Department of Health and Mental Hygiene Traturei', or items 23a or 28a-1 show eny injury or other traumatic event, II a Medical Examinar must be notified at once. 1 Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Ridge Rd 21157 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 SYYes 2 □ No If Yes, Give Year or Dates:1953-55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ğ Specify: Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unk Unk Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry E. Banning Unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharilyn Novak/Daughter 3467 Albantowne Way Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/8/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive heart **Physician** /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ the funeral director, page 2 should be Rena 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Pleural effusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending м 1 Tes 2 No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

\\\X\\
State

31. Date filed (Month, Day, Year)

M, D.

32 Registrar's Signature

Thysician

N 0 9 2007 Jan A Am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Kim

ORIGINAL

10 N. Greene Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

Registrar

			For	Plea	ase Type or State o			delible Ink artment of H					•	
			For State Registrar				Ce	rtificate of	Deati	h		Reg. N	.200	/ 0018/
i.	Physici		1. Decedent's Nam		lle, Last)	Brei	nnan				2. Date of D Month)ay Yea	3. Time of Death 8:30p. M
	/Medio			f not institutio	on, give street and no		iman	4b. City, Town, o		n of Death			lc. County of De	
**************************************	Funeral Director	dia -	5. Social Security N	lumber	6. Sex 1	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of E	Birth Day, Yea 26 1	9. B	irthplace (State or Foreign Country)
Sec.	ld restriction white		Usual Residence o								11 2	20 1	919	Scotland
	Aarylan f show ed at	or	MD 10a. State	10b. County	•	10c.	City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
	eath with the Marylan ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Nu	mber			Diffeot	10f. Zip Code				10g. (Citizen of What	Country?
	ath wi	ral	87-21 1	Haycarı	riage Ct.			2104					USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Mari 3 ☑ Widowed		Armed F rried 1 ☐ Yes	2 ∑ No live		Was Decedent of H If Yes, specity Cub 1 ☐ Yes 2 ☑ No			ecify Yes or N Rican, etc.)	10-	Black, WI	nerican Indian, nite, etc. Thite
0-0	2 hou latura ical Ex	ted		15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	pation			16b.	Kind of Busines	
21215-0036	within 7 liene. r than "r the Med	Completed by	Elementary/Seco		est grade completed College N/A	(1-4or 5+)		kind of work done DO NOT use retire	auring m d)	OSL OF WORK	ang		Retail	
	e filed al Hygi other vent, t	BeC	17. Father's Name	(First, Middle		1	Dare	SWOMBIT	18. Mol	her's Nam	e (First, Midd	le, Maid	- 1 - 1 - 1 - 1 - 1 - 1 - 1	
Maryland	ould b Menta arked	To.	Thomas			restor				Agne			McG.	
Mar	d 2 shi h and 7 is m traum		19a. Informant's N Peter Bi					ng Address <i>(Street</i> 1 Haycari						, — r ,
ē,	Healt Healt tem 2		20a. Method of Dis			20		osition (Name of matory or other pla			Date		Location - City	
Baltimore,	e = = ₽		4 ☐ Donation	5 Other (Madonna	Cemetery			/2007	Fo	rt Lee 1	New Jersey
Ball	permit. Pa Departmen Important; any injury once.		21. Signature of Fi	uneral Service	Elicensee	men		2. Name and Addre 101 E. No		IvI			AL HOME-	-EAST 21202
			23a. Part1. Enter t	the disease, o	or complications that st only one cause on	caused the d							re, rib	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	in		MONIA o (or as a con	sequence of):							Onset and Death
io.	製 in in in in in in in in in in in in in	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease of	enditions, nmediate erlying	Due to	o (or as a con	sequence of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit		that initiated event resulting in death)	5	d.	o (or as a con	sequence of):					_	·	
O. Box	the death certific y the attending p ched for use as	by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2] 9 ☐ Unknown	months?		birth 2 ☐ F gnant at time	Fetal death 3[□Ectopic pregnanc □ Other (specify) _	у				23d. Date of o	lelivery Day Year
Δ.	w requires that the de been signed by the s should be detached		Part II. Other signi	ficant condit	ions contributing to	death but not	resulting in the u	nderlying cause giv	ven in Par	t I.				to the cause of death? Probably 4 XIUnknown
al Records,	The lay ate has page 2	Completed									24a. Wa aul pei 1∐ Yes	topsy rform <u>e</u> d?	prior t	
Vita	Physician: r this certificanal director, i	Be	25. Was case refe examiner?		Hoopital:	71		ott			th <i>(Check only</i>			
0	Phy this	n: To	1 ☐ Yes 2 X 27. Manner of Dea		28a. Date	e of Injury	2 ER/Outpatie	" 20 DOY	4 🗆	Nursing Ho			6 XIOther (Sp jury occurred	pecify) HOSPICE
Division or Vital	r Attending er death. rector: After by the fune	Certification:	1 ▼ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could	igation I not be 28e. Place	enth, Day Yea be of injury - A ding, etc. (Sp	At home, farm, st		rk?]Yes 2	□No	28f. Location City or T	(Street	and Number or	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only one)	1X Certifyi 2 Medica	ing Physician: To the	basis of exan	knowledge, deat nination and/or ir	h occurred at the ti	ime, date	and place,	and due to th	ie cause	(s) and manner	as stated. ue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and	title of certifi		nner stated.		29c. Licens	se numbe	r		29d. [Date signed (Mo	nth, Day, Year)
	1		30 Name and add	rose of never	n who completed cau	se of death /	Itom 22a\ /Tim-	Dr. Print)	137	25			1/7/	07
	7		DR. TARI				EY VALLI		IMON	IUM.	MD 210	93		
	Sta Regist		31. Date filed (Mor			Begistrar's S	ignature	reals)		•				
	A			WITT V		The state of the s	- July	At Astron						

			For State	State of M	laryland /		artment o			ınd M		giene Reg. No	200	7 (10188
			Registrar 1. Decedent's Name (First, Middle, L	ast)			· imouro	0. 0	Jan		2. Date of De	ath	000		Time of Death
	Physicia /Medic		Walter A. Blot	tenberger							Januar	y z	ž, 2007	8	:30 P. M
	Examin	er	4a. Facility Name (If not institution, g)		4b. City, Tov		ocation o	f Death		4c.	County of D		
	**************************************	98	GILCHRIST CENTE. 5. Social Security Number 6.		ge (In yrs. last i	birthdav)	TOW:		If Under 2	24 Hrs.	8. Date of Birt	h	BALTIN 9. E		(State or Foreign
Ţ,	Funeral Director		215-09-0559	1 ⊠ M 2□F	92	Yrs.	Months D	ays	Hours	Min.	(Month, Da 6/1/19	y, Year) 14		Country) ARYLA	
22	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wp or L	neation							104 1	nside City Limits
	laryla shov	ō	MD BALTI	MODE.	Too. Oity, To		WSON								I∐Yes 2ŽŽNo
	the N	Director	10e. Street and Number	MOLLE			10f. Zip Co	de				10g. Cit	izen of What	Country?	
	h with 23a ol st be	al Di	8336 WYTON ROAD					2128	86				USA		
	ems (Funeral	11. Marital Status	12. Was Deceden Armed Forces		13.	Was Decedent If Yes, specify	t of Hisp Cuban	panic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, W		ndian,
36	s after	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates			1 □ Yes 2 X		Specify:		,			HITE	!
Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		15. Decedent's			Sa. Dece	dent's Usual O	ccupat	tion			16b. K	ind of Busine		у
215	hin 72 e. an "na Medio	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give life.	kind of work a DO NOT use n	lone du etired)	ıring most	of worki	ing				
2	filed wit Hygiene other the	Completed	12TH GRADE		· ·	MACF	HINIST_						IDIX CO	DRP.	
and	be fill ntal H ed oth even	Be	17. Father's Name (First, Middle, Las						18. Mothe MARIE		e (First, Middle, LTNT	Maiden	Surname)		
Maryland 21215-0036	2 should be filed and Mental Hygis Is marked other aumatic event, the	은	ARTHUR F. BLOTT 19a. Informant's Name/Relationship		1	9b. Maili	ng Address (St				. IIN al Route Numbe	er. City o	or Town, State	e. Zip Cod	de)
≅	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural" or items 23a or 28a-f show If item 27 is marked other than "natural" or items and the notified at or other traumatic event, the Medical Examiner must be notified at		DORIS B. BLOTTEN		E	8336	WYTON	RO	AD 7	rows	ON, MD	212	286		•
Baltimore,	iges 1 and 2 nt of Health If item 27 I or other tra		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	El Removal from State	reme	of Dispo	osition (Name o	of r place,	-		Date	20c. Lo	ocation - City	or Town,	State
Ĕ	permit. Pages Department of I Important: If its any Injury or o once.		4 Donation 5 Other (Spec				L CEME				2007		OKLYN		
3att	ermit. Depart mport iny Inj		21. Signature of Funeral Service Lic	ensee							JOHNSO				-
ě			23a. Part1. Enter the disease, or co	mplications that cause	ed the death. D		ter the mode o					WSON	I, MD	212 Apr	proximate
	Physician		shock, or heart failure. List on Immediate Cause (Final	y one cause on each	line.		772					,		Inte	erval Between set and Death
4	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequenc	ce of):		ep	Wo	jan				W	nes
100	Examiner		Sequentially list conditions,	bCO(on c	an	ur							M	MINS
7	sit sed	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequenc	e of).									_
_	execul n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequenc	ce of):								+	
8760,	cate be executed oblysician and the burial-transit	dical		d											
Ö	ntifica ng ph	Medi	IF FEMALE:												
Box	The law requires that the death certific tte has been signed by the attending pl tage 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3[⊒Ectopic pregr						23d. Date of Month	delivery Day	Year
o	that the de ned by the a detached f	ysic	1 Yes 2 No 9 Unknown	9□Unknown	at time of death	1 5[Other (special	<i>'Y)</i>							
σ, σ	s that ned by	by Pr	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying caus	e giver	n in Part I.		23e. Did t	obacco	use contribut	to the ca	ause of death?
ğ	w requires that been signed k should be deta	ed b									10	Yes 2	□ No 3 Z	Probably	4 □Unknown
Vital Records,	law ri as be	Completed									24a. Was	osy	prior	to comple	findings available tion of cause of
a H	i: The										1 Yes	rmed? 21.7No	death 1 U	i? 'es 2□	No
	Attending Physician: The law r death. ector: After this certificate has t by the funeral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 ER/	Outnatie	nt 3∏ DOA	Other	,-		n <i>(Check only d</i> me 5 ☐ Resid		6 A ther (S		A ALDÍCA
יסר	ding Phys n. After this funeral dir	n: To	27. Manner of Peath	28a. Date of In	jury 28t	b. Time o		Injury : Work?			28d. Describe l			pecity)	vosjove
<u>io</u>	endin eath. or: Aft he fur	atio	Vatural 5 ☐ Pending investigati	on	ay rear)	injury	М		es 2∐1	No					
Division or	at or Attend s after death, al Director: A ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d Zoe. Place of it	njury - At home, etc. <i>(Specify)</i>	, farm, st	reet, factory, of	ffice			28f. Location (S City or Tou			Rural Ro	ute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical (Physician: To the bes aminer: On the basis and manner:	of examination										
	To the within To the comple	×	29b. Signature and title of certifier						number				te signed (M	-	
	,		· you	S			V	5	85	03	2 (JAN	vary	32	007
	6		30. Name and address of person wh	o completed cause of	death (Item 23a	a) (Type,	Print)	1/1	aNI	18	+ RA	N	in a l	w 7	007
		te	31. Date filed (Month, Day, Year)	32-Regis	trar's Signature	101	14. (rv v	~ •	131	010	7-10L V	-1/	124

State Registrar

32 Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ackmon **Physician** Pauline 0125 06 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Center Anne Arundel Anna rundel Dolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 239-58-099 1 □ M 2 F North Carolina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 8how ir then "natural", or items 23a or 28a-f show the Medical Examinar must be collified at 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 813 205th Street U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Assembly Line Worker Calvert's Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Godwin Helen Duncan Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If itam 27 Harley Blackmon (Husband) 205th Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 1/9/07 Glen Burnie, Maryland 21. Signature of Funera 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Service Licensee M00922 3204 Mõuntain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or resultangue. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician an /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires that the death certificate be executed ng physicien and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 \(\Delta\) Inpatient 2 ER/Outpatient 3 DOA neral Director: After thi 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 21438 DEFENSE ATGHWAY ANNAPOLISMO 21401 cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

00000

WAU

2007

32. Registrar's Signature

Jef Bro

07-000 Arthur	061 Griffin Br	own		or Print in Black e of Maryland / De					egible.	
			1- For State Registrar		Certificate	of Death		F	Reg. No. ZUI	1/ 0013
Medic	Physici cal Exami		Decedent's Name (First, Middle, La ARTHUR	est) GRIFFIN BRO	WN JR			2. Date of De Month January	Day Year	3. Time of Death 0108 hrs
			4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town,	or Location of De		4c. County of De	
			St. Agnes Hospital			Baltimore			N/A	
	Funeral Director				rs. last birthday)	Months Da		Min	irth (MM/DD/YYYY) 9. Fo	reign
			216-74-0388 1 J. Usual Residence of Decedent	X M 2 F	48	Yrs.		Sept.	21, 1958	Country)Maryland
	any		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limit
	land f show	ō	Maryland N/A		Balti					1 X Yes 2 N
	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number			10f. Zip Code			10g Citizen of What C	
	vith the s 23a c e notif		4721 Pennington	Avenue 12. Was Decedent Ever i	n U.S. 113	212 Was Decedent of F		(Specify Yes or N	U.S.A	nerican Indian, Black,
	feath v ritem	Funeral	1 Never Married 2 Marrie	Association Comments		If Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)	White, etc	
	after ral". o iner n	by F		ed If Yes, Give Year or Dates	1[Yes 2 K			Specify: W	hite
	natur Fxam		15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	d) 16a. Deced	dent's Usual Occup most of working li			16b. Kind of Busine	ss/Industry
36	thin 7; ne than tedical	Completed	6	0		Roofer			Roofing	Industry
5-0036	iled wi Hygiei I other the M		17. Father's Name (First, Middle, Las	•			18.Mother's Na	ame (First, Middle,	Maiden Surname)	
2121	ld be f Jental Jarked event,	Be	Arthur G. Br		I 10h Moi	line Address (OL		chel	Henderson	
Z C	2 shour and N	2	Mary J. Grubb	(Fiance)					ore, Maryl	
	I and Health Fitem		20a Method of Disposition	21	Ob. Place of Disposer or Crematory or	position (Name of c	cemetery,	Date	20c. Location - City	
2	Pages nent of aut: 1		1 K Burial 2 Cremation 3 4 Donation 5 Other Specif	_)		i/11 Cemet	ery 0	1-08-07	Baltimore	, Maryland
Balfimore	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland opermit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Ī	21. Signature of Funeral Service Lice		222 M	Name and Addre	ess of Facility	Funeral 1	Home P A	
	hysician	-	23a art I Enter the disease, or com	ppligations that caused the de	eath Do not ente	37 E. Pater the mode of dying	apsco A	venue, Ba	altimore, I	Maryland 212
	/Medical		failure. List only one cause on e	each line. a Stab wound of chest				, ,		Between Onset and Death
	xaminer	4	or condition resulting in death)	Due to (or as a consequence						
		Į.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ce of):					
	-	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	2-2						
1	nted d ansit		events resulting in death) Last	Due to (or as a consequent	ce of):					
V	e executed rian and rial - transi	lical	UNPENDED	AMENDED		_				
Box 68760	eath certificate be executed attending physician and for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	regnancy				23d Date of deliv	уегу
89	n certif ending use as	cian	past 12 months?	1 Live birth 4 Pregnant at time o	-	Fetal death 3 Other (Specify)	Ectopic pre	gnancy	Month	Day Year
B	e death the att ed for	Physi	1 Yes 2 No 9 Unknow	9 Unknown		Ottler (Opcony)				
0	that th	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in th	e underlying cause	given in Part I			to the cause of death?
	equires en sig							- 24a Was		robably 4 Unknown autopsy findings available
Š	law re has be e 2 sho	Completed						auto		to completion of cause of
A R	n: The l tificate l or. page		25 Was case referred to medical			26 Plac	ce of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No
Z.	ing Physician: The law requires that the de After this certificate has been signed by the uneral director, page 2 should be detached f	o Be		Hospital: 1 Inpatient 2	✓ ER/Outpatie		Other	rsing Home 5	Residence 6 Ot	her:
وَ	ding Phy After the	Ë	27 Manner of Death	28a Date of Injury (Month, Day, Year) Jan 2, 2007	28b. Time o	of Injury 28c. Inj	jury at Work?	28d. Describe Subject was	how injury occurred	
ion	ttend death ctor: y the f	atio	Natural 5 Pending Accident Investiga	tion	2344 hrs		Yes 2 V No	Subject was	s stabbed	
Division of Vital Records	pital or Attenc ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could no determine			reet, factory, office	building, etc.	or Town, 9	State)	Rural Route Number, City
_	THE OF THE		4 V Homicide	cian: To the best of my know		curred at the time	date and place a		igleý Rd., Lansdowi	
	Fo the Hos within 24 h To the Fun completely	Medical		er: On the basis of examination						
	F 5 F 0	ž	29b. Signature and title of certifier			29c. Licer	nse number		29d Date signed (/	Month, Day, Year)

State 31. Date filed (Month, Day, Year) Registrar

-32. Registrar's Signature

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

mo

30 Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

January 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** \vdash^{IM} JANUARY. 2007 5:31 Abbot Boucher Bryant George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 5, 1922 Maryland Dec Director 216**-**16-1418 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No **Funeral Director** Marco Island Florida Collier 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6000 Royal Marco Way, #257 34145 12. Was Decedent Ever in U.S.

12. Was Decedent Ever in U.S.

13. Yes 2 □ No

15 Yes, Give

Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance 04 <u>Life Insurance Agent</u> other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Bryant Boucher, Jr. ၉ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 6000 Royal Marco Way, #257, Marco Island, FL 34145 <u>Jean W. Boucher/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any injury or oth 1/10/07 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 21. Signature Huneral Service Lo-n Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD Approximate Interval Between Onset and Death 23a. Part1. En er the disease, or complications that ca shock, or heart ailure. List only one cause on ea sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hiline. Immediate Carse (r nal disease or con thin n resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter United lying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 X No 1 Tyes 3 ☐ Probably 4 ☐ Unknown been sig should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an cate has t autopsy certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 28b. Time of Manner of Death

1 A Natural

2 Accident 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, doubt converted at the time. Hospital 29a. Certifier Medical bedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-05-0

-1.

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 30263

D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

		1 - For State Registrar	State of Ma	ryland / Dep Ce	artment of F			ene g. No. 200	7 00192
Physici		1. Decedent's Name (First, Middle, Last Frank R. B.					2. Date of Death Month		3. Time of Death
/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea	January	4c. County of E	
		Johns Hopkins	Bayview	Medicar	Baltim	nore cit	I	Balti	more city
Funeral Director		314-20-3923	ex M 2□F	(In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country) ndiana
and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Maryl -faho	tor	MD Balti	more		Co1gat	e			1 ☐ Yes 2 🛣 No
n the or 28a e.notil	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?
ath wi	rai	7914 Bank Street				21224		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Ham 27 Ia marked other than "natural", or Items 23s or 28s-f ahow any Injury or other traumatic avent, the Medical Examiner must be notified at ances.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No X	lispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, V	American Indian, Vhite, etc. White
hour tural	ed p	15. Decedent's Ed	Year or Dates:	16a. Deci	edent's Usual Occup	ation		6b. Kind of Busin	
hin 72	Completed	(Specify only highest gra		(Giv	e kind of work done DO NOT use retired	during most of wo	orking		,
od within 72 hours af giene. er then "natural", or ithe Medical Exem.	Com	Lionomary Good Tary (G 12)	4		puty Ward	en		Baltimor	e County
Inda y Idal IN Id 2 should be file Ith and Mental Hy IY Is marked oth traumatic avent	Be	17. Father's Name (First, Middle, Last)					ime (First, Middle, M	laiden Sumame)	
y y y y y y y y y y y y y y y y y y y	2	Unknown 19a. Informant's Name/Relationship (Tuna Print)	10h Mai	ing Address /Ctrant	Unknow	In Bural Route Number,	City on Tours Cha	to Zin Codel
od 2 s lith an 27 la r traur		Bruce Kern-Step-S					Len Burnie		
S 1 and 1 Heal	1 8	20a. Method of Disposition		20b. Place of Disp				Oc. Location - City	
rmit. Pages 1 a pertment of Her portant: If Itam y Injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		-	11e Cemet	1	3/07 C	rownsvi1	le, MD
permit. Depertm Importa any Inju		21. Signature of Funeral Service Licer	isee	2	22. Name and Addre	ss of Facility Ch	arles S.Z	eiler 🐧	Son, Inc.
8858	6 0	John Cit	10		6224 East	ern Aver	nue Baltim	ore, MD	21224
Physician / Medical Examiner physician and physician and physician and the prijal-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either unuenrying Cause (Disease or injury that initiated events resulting in death) Last	b. hypogy Due W (or acc	consequence of):					Onset and Death
eath certifi attending I for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 19 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy	1		23d. Date of Month	delivery Day Year
uires that the d	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did tob		te to the cause of death? Probably 4 Unknown
e law requir has been si je 2 should l	Completed						24a. Was ar		e autopsy findings available
The The ete has page	mo:						autopsy perform 1 ☐ Yes 2	ed? deat	r to completion of cause of h? Yes 2 No
ysicien: The is certificate director, pag	Be (25. Was case referred to medical examiner?					eath (Check only one		
Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 Propatier			4 🗀 Nursing	Home 5 Reside		Specify)
ding I	ion	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time Injury	Wor	yat k? Yes 2 ∐No	28d. Describe ho	w injury occurred	
or Attanding Physician: The law requires to effer death. Director: Affer this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	9	ry - At home, farm, s (Specify)		165 2 110	28f. Location (Str. City or Town,	eet and Number of State)	or Rural Route Number,
Hospita 4 hours Funeral ely filled	edicai C	29a. Certifier (Check only one) Certifying Ph 2 Medical Example	ysician: To the best on the basis of and manner state	examination and/or i	th occurred at the tin	me, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	11/0	O no	29c. Licens	e number	29	d. Date signed (M	fonth, Day, Year)
		/mull		-HI	RE	5 000	5	anvary:	5, 2007
15		30. Name and address of person who		ath (Item 23a) (Type					
6		Jennifer M. Cosa 31. Date filed (Month, Day, Year)		Johns 6	topkins B	oyview '	Medical Cent	c 4940	Eastern Ave.
Sta Regist		JAN 0 9 21	32. Hegistra	r's Signature	cook A			baltime	ore MD 2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fth 9863 1-9-07 vt. State of Maryland bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Frank M. C 0550 AM ragbu JANUARY 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216.36.637 Usual Residence of Decedent Director Maryland filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show Important: If Item 27 is marked other than any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore M 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Woodhowen Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Moving Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Crosby Sr.

19a. Informant's Name/Relationship (Type. Print) Ulenester ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Denise F. Jackson/Daughter 2100 Southland Road Guynn oak, mD 21207 (ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) adlawn Cemeter 101.12.07 Woodlaun, M 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Cyreene Juneral Service 8728 Liberty Rel Randalb town Vauyhn C. Greene Juneral Service 8728 Liberty 7cl Randouts town

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrythmin 15 minutes ardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End Unity to Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. the attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Records, Diabetes 1 Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performe Rena Discase 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Strige End Vital 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 SR/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BL9916795 2007 MA January 3rd, DEA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21229 Checkler 900 South Caton Avenue Meghan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 9 Registrar 2007

DHMH 17 Rev 1/2001

Œ

ANA

CARDS

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Joseph Edward Corbett 01/08/2007 11:59A^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2406 230th Street Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 1 X M 2 □ F 216-68-7842 51 06/18/1955 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 230th Street 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Environmentalist MD State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Corbett Regina Carr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Corbett / Wife 2406 230th Street, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 SCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 01/12/07 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner The law requires that the death certificate be executed

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once,

Physician

Examiner

Funeral

Director

of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

/Medical

Director

Funeral

\$

Be

10a. State

attending physician the cate has been signed by page 2 should be detacl After this certificate has been funeral director, page 2 should

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Examiner 2

Physician/Medical þ Completed Be

Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the f

State

Medical

Registrar

6 Could not be determined

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifier

Name and address of person who c cause of death (Item 29a) (Type, Print) MCa

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

 $Cogh.^{H}$, JohSaltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State of Maryland 1- Registrar Amend #29d per DVR G863 1	a / Depar L/0 99€7	ifi g ate of i	ieaith and Death	ı ivlental Hy	/gien Reg. N	2007	00196
Physici	an					2. Date of D Month		ay Ye	3. Time of Death
/Media	cal	John Robert Coghill 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of De	JANUARY	/ 2	. 200 c. County of D	7 10:05 M
Examir	ier	BALTIMORE Washington Medic	4/ (But	es Gen	U BURI	014		nne	Acurdel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, D	ay, Yeal	7	Birthplace (State or Foreign Country)
Director		217-30-4433 Table M 2 73	118.			04/1	0/19	933	MD
ryland how at		10a. State 10b. County 10c. City,	, Town or Loca	tion					10d. Inside City Limits
e Ma 8a-f s	Director		sadena						1 □ Yes 21 No
with the a or 2 the no	Dir	10e. Street and Number		10f. Zip Code			_	itizen of What	Country?
death ms 23	Funeral	1814 Parkside Drive 11. Marital Status 12. Was Decedent Ever in U.S	6. 13. Wa	2112 as Decedent of H		(Specify Yes or Nerto Rican, etc.)			merican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 No 195 1 Yes 2 No 196 1 Yes 3 Widowed 4 Divorced 2 Yes 196 1 Yes Give Year or Dates:	_	Yes, specify Cuba	an, Mexican, Pu Specify:	erto Rican, etc.)		Black, W Specify:	White, etc. White
"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occup nd of work done of NOT use retired	ation during most of v	vorking	16b. I	Kind of Busine	ss/Industry
withir iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		enter	1)		Ca	binet	rv
be filed ttal Hyg d other event, i	BeC	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle			-1
2 should b and Ment is marked aumatic e	P P	Edgar William Coghill				ie Eliz			
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)				Rural Route Numi			
s 1 and F Health tem 27 other tr			ace of Disposit	ion (Name of	i	Date Pa			MD 21122 or Town, State
Pages nent of h int: If its ury or of		1 Buriai 2 Ucremation 3 Hemoval from State	•	tory or other place dαe Mei	· i	/06/07	Ba	alt.imc	ore, MD
permit. Departir Importa any inju		21. Signature uneral Sovice Licensee							1 Home, PA
9 9 1 1 1		Jul To						dena,	MD 21122
		Z3a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final			ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a	Ailer	•					
Examiner		Colon C	CANCEL	•					
p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):		-			. ,,,,	
fificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	ence of):						
e be e sician buria									
tificate ig phy: as the	ledical	0.							
eath cer attendin I for use	by Physician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal		ctopic pregnancy	1			23d. Date of	
w requires that the death cer been signed by the attendir should be detached for use	ysici	1 Yes 2 No 9 Unknown 9 Unknown	ath 5□C	Other (specify)				Month	Day Year
that the	/ Ph	Part II. Other significant conditions contributing to death but not result	ting in the und	erlying cause give	en in Part I.	23e. Did	tobacco	use contribute	e to the cause of death?
quires n sign uld be						_ 1_	Yes 2	Mo 3□	Probably 4 Unknown
law re as bee 2 sho	Completed					24a. Was		24b. Were	autopsy findings available
The cate has page	Com						ormed?	death	to completion of cause of i? 'es 2 □ No
i cian : certific	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othe	or:	eath (Check only			
Phys r this eral dir	은 -	27. Manner of Death 28a. Date of Injury	28b. Time of	3 DOA Othe	4 LI Nursing	Home 5 ☐ Res 28d. Describe			pecify)
nding ath. r: Afte e fune	ation	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		k? Yes 2∐No			,	
rr Atte ter dea irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hon building, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Street a	nd Number or	Rural Route Number,
pital o urs af eral D		200 Codifier 45 Contificing Disprisions To the heat of my least	de des de de						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifler (Check only one) 15 Certifying Physician: To the best of my know (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	neage, aeath a ion and/or inve	stigation, in my o	ne, uate and pla ppinion, death oc	ace, and due to the ocurred at the time	cause(s , date ar	s) and manner nd place, and o	as stated. due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier		29c. License					onth, Day, Year)
1		Henry trong		Doz	7415		JAN	wary a	2, 2006
5		30. Name and address of person who completed cause of death (Item 2)	altimo	re WAS	chirgon	Melic	rl	Cent	er
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signat.	H. An	and the					
3		JAIN O SOO! PARTY	50	502					

07-00175	han	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Le	gible.
Michael Cunning		1- For State Certificate of Death	2007 0019
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Dea	
Medical Examin		Michael Cunningham January 6	
(4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral			rth(MM/DD/YYYY) 9. Birthplace (State or
Director	Į	216-78-8385 1XM 2 F 46 Yrs. Months Days Hours Min. Aug. 3	23,1960 Foreign Country) Md.
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	اۃ	Md. NA Baltimore	1 Yes 2 No
Maryla	Director	10e. Street and Number 10f. Zip Code 1	log. Citizen of What Country?
ith the	ä	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No	USA Base American Brian Black
leath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No	o- 14. Race - American Indian, Black, White, etc.
after d	쥰	3 Widowed 4 Divorced if Yes, sive Year 1 Yes 2 No specify:	Specify: Black
2 hours "natur	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
2	dmo	12 0 Machine Operator	Private Firm
215 be files ntal Hy rked o	Be C	Sutherland I Cunningham Rith Forau	son Johnson
D 21 should and Mei 7 is mai	유	19a. Informant's Name/Relationship (Type, Print) 51 Ster 11b. Mailing Address (Street and Number or Rural Rou Number of Rural	
and 2 stealth a	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
MOFe, Pages I ar		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Dundalk Md
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	ŀ	21 Signature of Funeral Service Licensee 22 Name and Address of Faulity	sal Home RA
	37	23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm	md. 21216
Physician /Medical	104	(faflure, List only one cause on each line.	rest, shock, or heart Approximate Interval Between Onset and Death
ixaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunsnot Wounds Due to (or as a consequence of):	
	<u>ا</u> ھ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examine	causs. Enter Underlying Causs (Disease or injury that initiated	
ecuted and and transit		1	
ĕ	an/Medical	UNPENDED AMENDED	
68760, certificate bo nding physic se as the bur	18	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ox 687 eath certific attending p	sicial	4 Pregnant at time of death 5 Other (Specify)	Month Day Year
by the attents ached for us	袓	9 Unknown	obacco use contribute to the cause of death?
P.O. es that the igned by oe detach	<u>a</u>	Ye	s 2 V No 3 Probably 4 Unknown
of Vital Records, P.C. ng Physician: The law requires that After this certificate has been signed uneral director, page 2 should be det	Completed	24a. Was autor	
Reco	E O	perfo	ormed? death?
tal R	8 8	25. Was case referred to medical 26.Place of Death (Check only one)	
n of Vital Rec ding Physician: The After this certificate funeral director, page	의	1 Ves 2 No Inpatient 2 V ER/Outpatient 3 DOA Oute4 Nursing Home 5	Residence 6 Other:
ion of tending eath.			
Division pital or Attendi ours after death filled in by the fi	ertification	2 Accident Investigation Jan 6, 2007 1841 hrs 286. Location (3 Suicide 6 Could not be Could not be Could not be 19 Could not b	Street and Number or Rural Route Number, City
Division Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	ပြု	20g Cartifier	eadý Avenue , Baltimore , MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	dical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date	
To viti	⊕ ⊦	and marrier stated.	29d. Date signed (Month, Day, Year)
		(an so HO O O O O O.C.M.E.	January 7, 2007

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

ORIGINAL

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

herritta M. Cott		State O		ent of Health and Mental F te of Death		2007	nnia
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middle,Last)	M CH.	ne or beaut	2. Date of Death Month Da January 5, 20		3. Time of Death
Medical Exami		4a. Facility Name (if not institution, give s		4b. City, Town, or Location of Deat Baltimore		4c. County of Death	
Funeral Director	į	5. Social Security Number 6 Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hr Months Days Hours Mil		MM/DD/YYYY) B. Birth Foreign Cour	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at once.	Be Completed by Fune	Usual Residence of Decedent 10a State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If 15 Decedent's Education (Specify only Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Typ MS. Michele 20a. Method of Disposition	10c. City, Town of Ball 1 Are Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Yes, Give Year highest grade completed) College (1-4 or 5+) College (1-4 or 5+) Are Print 1 Removal from State Removal from State	or Location In Ore 10 2/2/7 13. Was Decedent of Hispanic Origin? (Solf Yes, specify Cuban, Mexican, Puert 1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of uring most of working life. DO NOT use resulting the property of Market Solf Yes Name and Address of Facility. 18. Mother's Name of Cemetery. 19. Mount Crematory. 122. Name and Address of Facility.	Specify Yes or No- o Rican, etc.) work done 16 tired) E Fhi Rural Route Number	Citizen of What Count USA 14 Race - Americ White, etc. Specify. Blace Button City den Surname)	an Indian, Black, LCK dustry Zip Code) Md, 21239
Physician /Medical Examiner		Immediate Cause (Final disease a		enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
d sit	Examiner	cause Enter Underlying Cause	ue to (or as a consequence of): ue to (or as a consequence of).				
0, be executed sician and ourial - trans	edical E	X UNPENDED		ME, g864, 2/21/07 TT			
Box 6876C he death certificate the attending phys	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	nancy	23d Date of delivery Month Da	ay Year
P.O.	Completed by Ph	Part II. Other significant conditions	ontributing to death but not resulting	ın the underlying cause given in Part I	1 Yes 2 24a Was an autopsy performe	prior to co	
Vital Rec ysician: The his certificate	Be Cor	25. Was case referred to medical examiner?	spital 1 Innationt 2 ER/O	26.Place of Death (Check Itoatient 3 DOA Other Virginia Nurs			
Division of Vital Records, tell or Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation	28a Date of Injury (Month. Day Year) 28a Date of Injury (Month. Day Year) Fnd 1/5/2007 Fnd 28e Place of Injury - At home fa	intended in the property of th	28d. Describe how subject dro	· · ·	
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide determined 29a Certifier (Check only 1 Certifying Physician	(Specify) bathtub To the best of my knowledge, dea	th occurred at the time, date and place, an	Apt 210 Balt nd due to the cause(s	timore, MD) and manner as stated	d
To t with To t	Medical		Unit	29c. License number O.C.M.E.	29	9d Date signed (Moni	
		30. Name and address of person who co Margarita Korell MD. Ass		111 Penn Street, Baltimore, MD	21201		

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

58-1602915XI

Edward Lee Canup 07-00115 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea No Registrar Time of Death Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Month 0304 hrs **Medical Examiner** January 5, 2007 Edward L. Canupp 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death Baltimore 538 Maude Avenue Baltimore City 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Foreign Min Months Days Hours Director Country) 1 X M 2 F 61 10-04-1945 214-46-1482 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b County Yes 2 X No 5re, MD 21215-0036
ss 1 and 2 should be filed within 72 hours after death with the Maryland
of Health and Mental Hygiene
If item 27 is marked other than "natural", or items 23a or 28a-f show her tranmatic event, the Medical Examiner must be notified at once. Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 Talbot Court 21122 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 2 X Married Armed Forces' 1 Never Married 2 X No Yes white Widowed 4 Divorced If Yes Give Year Yes 2 X No specify. Specify: ≥ 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machinist Automobile 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Marion Canupp Janie S. Shue 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marsha Canupp / wife 4304 Talbot Court; Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 Important: injury or oth 1-12-2007 ent Glen Haven Mem. Park Glen Burnie, MD Donation 5 Other Specify 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 MO135 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Ilure List only one cause on each line Between Onset and /Medical Death a Blunt Force Injuries of the Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ σ. Yes 2 V No 3 Probably 4 Records, Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 ✓ Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other 4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 🗸 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Manner of Death Certification: Subject beaten FOUND: Natural 1 Yes 2 V No Pending the Director: Jan 5, 2007 0220 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 538 Maude Avenue, Baltimore, MD determined (Specify) Townhouse / Rowhouse 4 V Homicide

NC

Year

29d Date signed (Month, Day, Year)

January 5, 2007

Hospital or Attending Physician: Division of Vital within 2.

> 30. Mame and address of person who completed cause of death (Item 23a) 5 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) State

> > 0

29a Certifier 1

Signature and title

one)

Medical

111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 **Physician** 6:00 PM SYLVAN COHEN Varuary 2007 */Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ROLAND PARK PLACE BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/10/1918 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 215-12-7265 88 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show MD 1 Ves 2 □ No Director N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 830 W. 40TH STREET #114 21211 USA death v Funeral 7 Is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc filed within 72 hours after Atmed Forces? 1 Xi Yes 2 □ No WW II If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ al Hygiene. Elementary/Secondary (0-12) DENTIST DENTISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h Be LOUIS COHEN LILLIE KOPLOWITZ ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I FRANCES COHEN / WIFE 830 W. 40TH STREET #114 - BALTIMORE, MD 21211 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTEFIORE CEM. 01/08/2007 HALETHORPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-stax demention du to asperments **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown certificate has been signed ector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **№** No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number

n. ISABELLE State Registrar

MARGREGOR, 830 W. 40 Yh STREET, BALTMORE, DOD 21211 31. Date filed (Month, Day, Year) JAN 0 9 2007

VI Habello



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D13657

29d. Date signed (Month, Day, Year)

		-	State of Maryland		artment of He rtificate of D			20	0.7	00201
			Registrar 1. Decedent's Name (First, Middle, Last)		tineate of L	- Catri	2. Date of Deat	eg. No. 🚄 🔱 th	0 1	3. Time of Death
	Physicia /Medic	_	Anthony S. Cieri				JANUA	RY ^{Day} ∃,	Year 2001	05:20AM
).	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cen	ter	4b. City, Town, or	Location of Death		4c. County		timore
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia. 138–12–3199 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) July 30	Year)	9. Birthp	place (State or Foreign htry)
	Director	-	138-12-3199 85 Usual Residence of Decedent				July 30	, 1921		NJ
	yland now at		10a. State 10b. County 10c. City,	Town or Lo	cation	,				10d. Inside City Limits
	a-fsh	ctor	MD Baltimore Re	eister	stown					1 □ Yes 2 🔯 No
	or 28	Dire	10e. Street and Number		10f. Zip Code		1	0g. Citizen of		ntry?
	ath w	ral	307 Cherry Chapel Road	1 10 1		.136	posifu Vac or No		USA	can Indian,
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 🛣 No	Specify:	Rican, etc.)		ck, White,	
200	tural	ed k	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of B		
5	nin 72 F. In "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done d DO NOT use retired	luring most of work)	king			1
7	d with	E C	12		Bartender			Ва		
	tal Hy d other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, i	Maiden Surnar	ne)	
<u>X</u>	ould b Ment arked	P.	Joseph Cieri				ssie Ior			
0	12 sh and rsm		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a					
ນ໌ ປ	1 and Health em 27 ther t				Cherry Cha position (Name of matory or other place			20c. Location		
	ages nt of l :: If ite		1 LXBurial 2 Li Cremation 3 Li Removal from State	-	-	i i			•	
altimor	artme ortani injun		4 □ Donation 5 □ Other (Specify) Dru 21. Signature of Funeral Service Licensee	11d R1	dge Cemet 2. Name and Addres	:ery; 1/8; is of Facility		<u>Pike</u> Reiste		e, MD
0	permir Depar Impor any Ir		Kamb O'livi	F	line Fune	ral Home		rstown		
Š.			23a. art1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician		Im ediate Cause (Final dase or condition ASPIRATIO							Onset and Death
,	/Medical		resulting in death) Due to (or as a consequence)							
	Examiner		Sequentially list conditions. b.						_	
	Ps it	ine	Sequentially list conditions, if any leadin, to immediate cause. Enter underlying Cause (Disease or Injury that initiated events c.	ence of):					0)	
_	xecute and Il-tran	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence)	ence of):					-	
2/00	icate be executed physician and the burial-transit	dical E								
000	ficate g phys	edic	0.	- 11						
gox	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3[⊒Ectopic pregnancy ⊒ Other <i>(sp</i> ec <i>ify)</i>				ate of deliv	rery Day Year
Ċ.	t the by the ache	Phys	9 ☐ Unknown							
ras, r	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resul ANEMIA	Iting in the u	inderlying cause give	en in Part I.	23e. Did to	1/		the cause of death?
Hecords	sician: The law re certificate has bee irector, page 2 sho	Completed	RENAL FAILURE				24a. Was a autop perfor		Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vitai	ian: ertifice ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or			
o -	Physician: r this certific ral director,	To	1 Yes 2 No Hospital: 1 Inpatient 2 E		nt 3 DOA Othe	4 □ Nursing H	ome 5□Resid			ify)
	Ing P		1 Natural 5 Pending (Month, Day Year)	28b. Time o Injury	Worf		28d. Describe h	ow injury occu	rred	
<u> </u>	ttend Jeath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At hor	me farm et		Yes 2 □ No	28f Location (S	Street and Num	her or Ru	ral Route Number,
DIVISION	al or Attending Ps after death. Il Director: After set in by the funera	Certification:	4 ☐ Homicide determined building, etc. (Specify,))	rect, lactory, office		City or Tow	n, State)	ber or riar	ar riodic rearmon,
	Hospit 4 hours Funera tely fille		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated	wledge, deat ion and/or in	th occurred at the tin	ne, date and place pinion, death occu	e, and due to the durred at the time,	cause(s) and m	nanner as , and due	stated. to the cause(s)
	To the within 2 To the comple	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License	e number		29d. Date sign	ed (Month	, Day, Year)
) ()		D37	254		1/3	10;	7
7	4+1		30. Name and address of person who completed cause of death (Item	23a) (Type,						
	7		BOON POH LIM, M.D. 7601	OSLEF	R DRIVE	TOWSON	, MARYLI	AND 21	204	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture	Acres .					
	Regist	rar	JAN 0 9 2007 Jane	15.	A CONTRACTOR OF THE PARTY OF TH					

07-00173

Katherine D. Da		osia Š 1- For State	tate of Ma	aryland /		rtment of tificate of	Health an	d Mental	Hygiene	2.0	10.7	0000
Physici	_	Registrar 1. Decedent's Name (First, Mide	de,Last)		Cer	incate of	Dealli		2. Date of De			3. Time of Death
Medical Exami	ner	Katherine		D.			mbrosia		Month January			1915 hrs
		4a Facility Name (if not instituti Pulaski Highway at N				14	b City, Town, or Middle Rive		eath	4c. County o		tv
Funeral		5. Social Security Number	6 Sex		e (In yrs. Ia	ist birthday)	If Under 1 Yea	ar If Under 24	4Hrs 8 Date of E	Birth (MM/DD/YYYY)	9 Birth	
Director		215-88-3088	1 M 2	ΧF		33 Yrs.	Months Day	s Hours	Min. Augus	st 9,1973	Foreign Cour	ntry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County			10c. City.	Town or Location	n				11	Od Inside City Limits
.	_	Maryland Balt	imore		E	Edgemere	<u> </u>				- 1	1 Yes 2 XNo
Maryland 28a-f show d at once.	ادة	10e. Street and Number		<u>_</u>			10f. Zip Code			10g. Citizen of Wha		y?
ith the Mary 23a or 28a- notified at 6		7323 Geise Aver						219		USA		
eath wi items ust be	Funeral	11. Marital Status 1 Never Married 2 X	larried Ar	as Decedent med Forces?			Decedent of His s, specify Cubar		(Specify Yes or Nerto Rican, etc.)	Io- 14. Race White		an Indian, Black,
after da al", or	by Ft	3 Widowed 4 Di	vorced If Yes, G		No	1	Yes 2 X No	specify:		Specify.	Whi	te
hours natur	ted t	15. Decedent's Education (Spi Elementary/Secondary (0-12		est grade com			s Usual Occupa st of working life			16b. Kind of Bus	iness/Ind	dustry
336 thin 72 re than '	Completed	12 years		years	· .	Parmace	eutical	Repres	entative	Pharma	ceut	ical
21215-0036 uld be filed within 7 Mental Hygiene, marked other than		17. Father's Name (First, Middle	, Last)					18.Mother's N	ame (First, Middle	, Maiden Surname)	_	
2121 Ild be f Mental marked event,	To Be	Elmer Matthew 19a. Informant's Name/Relation				19h Mading	Address (Stree			n Shipley		Zin Codo)
MD 2 d 2 shou lith and 1 n 27 is r	-	Elmer & Joreatha C		Paren	its					Maryland		
	Ī	20a Method of Disposition 1 X Burial 2 Crematic	n 3 Rem	oval from Sta	20b. P	lace of Disposi rematory or oth	ion (Name of ce er place) aith Ceme	metery, J	anuary	20c. Location -		
Baltimore, Dermit Pages I at Department of Her Important: If ite		4 Donation 5 Other S	pecify:		Gard			tery 1	1, 2007	1	-	Maryland
Bal permin Depar Impo	ļ	21 Signature of Funeral Service	Licensee	naio	00,	/ Cor	me and Address nelly F	uneral	Home Of	Dundalk, Dundalk,	P.A	11222
Physician		23a Part I. Enter the disease, of failure. List only one daus	r complications	that caused	the death.	Op not enter th	e mode of dying,	such as cardi	ac or respiratory a	rrest, shock, or hea	rt T	21222 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	a. Multip	le Injuries								Death
			Due to (or as a conse	equence of):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		or as a conse	equence of):						
¥ .=	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	or as a conse	quence of):						
be evecuted by its sician and urial - transit		LINDENDED	d	IDED.					-		_	
	Medical	UNPENDED IF FEMALE:	AMEN 23c	If yes, outcom	ne of pregn	iancy				23d Date of	dolucon	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. After this certificate to the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	sician/M	23b. Was decedent pregnant in past 12 months?	he 1	Live birth		2 Fet	al death 3	Edopic pre	egnancy	Month	Da	y Year
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 🗸 Ur	nknown 9	Pregnant at Unknown	time of dea	5 Oth	er (Specify)					
P.O. Bo es that the deat igned by the at	by Phys	Part II. Other significant cond	tions contrib	uting to death	but not re	sulting in the ur	iderlying cause (given in Part I.		tobacco use contrib		
ords, P.O w requires that is been signed be should be detay									1 Y			bly 4 Unknown
cords law requi	Completed								auto	ppsy pr		psy findings available mpletion of cause of
tal Rec cian: The l certificate P		25 Was case referred to medic	al				26 Place	e of Death (Ch			√ Yes	2 No
Vital hysician: this certiful director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	1 Inpatie	nt 2	ER/Outpatient		Othor	ursing Home 5	Residence 6	Other: §	Scene
Division of Vital Records, tal or Attending Physician: The law require attendent and briercer: After this certificate has been sited in by the funeral director, page 2 should b	L H	27. Manner of Death 1 Natural 5 Page	lo.	n. Date of Injur (Month Day,Yean 6, 2007		28b Time of In		iry at Work?	Passenger	how injury occurre		Jck by car
Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certification:	2 Accident Inve	estigation				, factory, office b	Yes 2 ✓ No	and eject	ed		Route Number, City
Div pital or ours afte	ertif		lid not be			l / Highway	, 140.07), 011100 1	ouriality, oto.	or Town,	State)		, Middle River, MD
D e Hospital n 24 hours : e Funeral letely filled		1								use(s) and manner		
To the Howithin 24 h	Medical	one) 2 Medical Ex 29b. Signature and title of certif	and ma	basis of exam anner stated.	mination ar	na/or investigati	on, in my opinion		ed at the time, dat	e and place, and du 29d. Date signe		
		110111 100	n. il	Gill			O.C.			January 7, 2		i, Day, 1841)
		30. Name and address of perso	n who complete	ed cause of de	eath (Item	23a)						
V	ل	Margarita Korell MD.	Assistan	t Medical			nn Street, B	altimore, M	1D 21201			
Si Regis	tate trar	31. Date filed (Month, Day, Year	2007	32. Registrar	s Signatu	Laga	80					

			1 - For State Registrar	State o	f Marylar		artmen <i>rtificat</i>			nd M		giene	007	00203	}
	Physici	an	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Yeer	3. Time of Death	
	/Medi		Helen Ruth Dear								1/7/07			5:27 a.m.	
	Examir	ner	4a. Facility Name (If not institution	-					Location of	Death			ounty of Dea		
	Funeral		7734 Washingtor 5. Social Security Number	6. Sex	LOT 94 7. Age (In yrs.	. last birthday)	ff Under		If Under 2		8. Date of Bir	th	ward (thplace (State or Foreign	n
	Director		578-34-8820 Usual Residence of Decedent	1 □ M 2 XX F	79_	Yrs.	Months	Days	Hours	Min.	(Month, Da 6/11/19			shington, D	
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits	
	9 Mar	ctor	MD Howard	l	Elk	ridge								1 ☐ Yes 2√CXNo	1
	ith th	Director	10e. Street and Number				10f. Zip	Code				_	n of What Co	ountry?	
	s 23e		7734 Washington		ot 94 edent Ever in U	10 12		1075	anania Oria	im2 (Cm)	ecify Yes or No	USA	Bace - Ame	erican Indian.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f ehow any injury or other traumatic event, Ira Medical Evantral must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Fo	orces?		If Yes, spec	cify Cubai	n, Mexican,	Puerto	Rican, etc.)		Black, Whit	e, etc.	
936	el', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes	2 🔀 No	Specify:			Sp	pecify: Wh:	ite	
5-0036	72 ho	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usua kind of wo	rk done a	luring most	of worki	ng	16b. Kind	of Business	/Industry	
2121	Aithin De. Me.	ig m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT u:	se retired,)			-			
2	Hygie Hygie ther t		12 17. Father's Name (First, Middle, I	ast)		Secre	tary_		18. Mother	r's Name	(First, Middle,	Pepc Maiden Su			
Maryland	ental sental ked o	To Be	Elmer Charles E								anche S		,		
ary	shoul and M	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a			I Route Numbe		own, State,	Zip Code)	
Ž	and 2 paith a n 27 in		William Boswell	'Son					on Bly	vd.,	Lot 94	. Elk	ridge,	MD 21075	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from		Place of Dispo cemetery, cre	osition (Nar matory or o	me of other place	9)		Date	20c. Loca	tion - City or	Town, State	
Ë	Pag tment tant:		4 □Donation 5 □ Other (S _i	oecify)		ro Cre				1/9/	07	Caton	sville	e, MD	
Baj	Deparition Departiment Important		21. Signature of Funeral Service I	//		~	T	Trans.	s of Facility	**	eral Ho	me 0	ммр. з	Inc.	
			Ja Pin1. Enter the diseas or shock, or heart failure. List	polio tions that of	caused the dea	ith. Do not en	250 W	ashir	ngten	Plaz	d., Elk	ridge	, MD	21075 proximate	_
	Physician	8 1	Immediate Cause (Final	only e cause on e	each line.	C 00	. 1	0 /	7	C.	- A Sola				
7	/Medical		disease or condition resulting in death)	a	(or as a conse	quence of):	-coe	4/	+4	6 22	rctro		-	5 hours	_
н	Examiner		Sequentially list conditions	b											
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):									
	icate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):									
8760,	sicien buris	alE		l a											
9	certificate Iding physise as the	Physician/Medical		T											
Box		an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregr pirth 2 ☐ Fet		∃Ectopic pr	regnancy				230	d. Date of de	,	
	0 0	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown		nant at time of		Other (sp						Month	Day Year	
P.0	requires that the een signed by th nould be detache		Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the	anderlying o	alica diva	n in Part I		23e Did t	obacco use	contribute to	the cause of death?	
ds,	signe d be d	Completed by	Husery	Leu Jo			and only mig o	auso give	,, ,,,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10			robably 4 Unknown	1
Ö		ete									24a. Was	an 2	24b. Were au	utopsy findings available	В
Re	sician: The law scertificete has b lirector, page 2 s	E O									autor	osy ormed?	prior to death?	completion of cause of	
tal	an: T tifficet for, p	BeC	25. Was case referred to medical		1176	- Jan 10 / m .			26. Place	of Death	1 Yes	22 No	1 LI Yes	2 □ No	
Ţ	ysici iis cer direc	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1 🗆	Inpatient 2] ER/Outpatie	nt 3 DC	OA Othe			me 5 Resi		Other (Spe	cify)	
0	ng Pt fter th ineral		27. Manner of Death 1 ☑ Matural 5 ☐ Pendin	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o	if 2	28c. Injury Work	at ?		28d. Describe I	now injury o	occurred		
Sio	tendi Jeath. tor: A the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation		<u> </u>	М		res 2□N		00/ 1			- : -	
Division of Vital Records,	al or At s after of I Direct d in by	Certification:	4 Homicide determ	ned 286. Place	of Injury - At h ing, etc. (Spec	nome, farm, st ify)	reet, factory	y, office			City or To	street and N wn, State)	vumber or Hi	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai (g Physician: To the Examiner: On the b											
	vithin o the	Med	29b. Signature and title of certifier	wind mail			290	c. License	number			29d. Date s	signed (Mont	h, Day, Year)	
			1) Dan	NO Bin	caue	redu	,	D	/>:	57	>>	1	9/	27	
	15		30. Name and address of person	who completed cau		m 23a) (Type,	Print)		1.4			,	. / .	N -	
			D. Oranite	eous	1150	erfe	evas	g	ree	ub	clt, o	W =	202	20	100
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32.4	legistrar's Sign	ature,	perty)	9			-				

07-00084 Mary C. Duke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Registrar Certificate		Reg	No 2007 00	120
Physic Medical Exam				2. Date of Death Month D. January 3, 2	ay Year 1733 hrs	
	ر نعو	4a Facility Name (if not institution, give street and number) 5401 Old Court Road	4b. City, Town, or Location of Dea	ath	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Randallstown y) If Under 1 Year If Under 24H	rs. 8. Date of Birth (Baltimore County MM/DD/YYYY) 9. Birthplace (State of	Or
Director		$217-06-5190$ $_{1_M}$ $_{2X_F}$ 37		July 1	1,1969 Foreign Maryla Country)	
ıny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d Inside Cil	ity Limite
Aaryland 28a-f show any Lat once.	ō	MD Politimore	Randallstown		1 Yes 2	-
ie Maryli or 28a-f	Director	10e. Street and Number 3800 Kilburn Road	10f. Zip Code 21133	10g.	Citizen of What Country?	
with the Maryland ns 23a or 28a-f sho be notified at once.			. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian, Blace	
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc. White	O.N.
urs afte tural",	d by	3 Widowed 4 X Divorced If Yes, Give Year 1	Yes 2 X No specify: edent's Usual Occupation (Give kind o	f work done	Specify: b. Kind of Business/Industry	
36 n 72 ho nan "na icat Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use re Omemaker	etired)	At Home	
5-003 ed withi ygiene other th	Som	12 17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
21215-0036 unld be filed within 7 Mental Hygiene marked other than	Be	John Michael Duke	Doro	thy Jean H	lelms	
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland in an 15 is marked other than "matural", or items 23a or 28a-f shu aumatic event, the Medical Examiner must be notified at once	5	John Michael Duke-father 38	ailing Address (Street and Number of 00 Kilburn Road-R	r Rural Route Number andallstow	r, City or Town, State, Zip Code) n, Maryland 21133	,
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Montal Hygien II Important: If frem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation 3 Removal from State Lakevier			oc. Location - City or Town, State Sykesville, Maryl	and.
Baltir Departme Importa		21. ature of Funeral Service Licensee	ens 22. Name and Address of Facility EVANS FUNERAL CHAI	PET, 8800	Harford Roa 2	1234
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent	יסיבים זארדיתאיםסים רוואג	итстве Ра	rkville.Marvland	<u> </u>
/Medical Examiner		Immediate Cause (Final disease a Diabetic ketoacidosis			Between On: Death	
1		or condition resulting in death) Due to (or * s a consequence of): Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
cuted ind transit	Exan	events resulting in death) Last Due to (or as a consequence of):				
exe	edical	M UNPENDED AMENDED #23a.PTT.27.per	ME, G863,1/26/07 TT			
	₹	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68 death certiff the attending of for use as	hysician	Pregnant at time of death 5	Fetal death 3Ectopic pregr Other (Specify)	nancy	Month Day Ye	ear
O. Bc at the dee d by the a	₽	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	23e. Did tobaco	co use contribute to the cause of dea	ath?
s, P.O. nires that the r signed by the detache	ed by	Hypertensive atherosclerotic cardiovascu	ılar disease	1 Yes 2		
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	Completed			24a. Was an autopsy	24b. Were autopsy findings as prior to completion of cau	vailable use of
tal Rection: The certificate ector, page		25. Was case referred to medical	00 Plane (Part) (0)		1	No
Vita hysician this cer	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpate	26.Place of Death (Check tent 3 DOA Other Nursi		idence 6 Other:	
	in o	27. Manner of Death 1 X Natural Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury at Work?	28d Describe how i	injury occurred	
Division tal or Attendir rs after death al Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Stree	t and Number or Rural Route Numbe	er. City
Diversal or hours at neral D		4 Homicide determined (Specify)		or Town, State)		., .,
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated.	curred at the time, date and place, an igation, in my opinion, death occurred	d due to the cause(s) at the time, date and p	and manner as stated place, and due to the cause(s)	
	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
95	1	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Ja	anuary 4, 2007 —————-	
0		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimo	re, MD 21201		- 1
St Regist		5 MAR A O CO	28482			

Mary Agnes Davis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day January 2, 2007 **Medical Examiner** 0526 hrs Mary A. Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Raltimore N/A 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6 Sex If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Months Days Director Hours 217-72-5492 48 Oct 19 1958 Country)Georgia 1 M 2 X F Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. Maryland Anne Arundel Annapolis 1 XYes 2 No 28a-f show death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1852 Bowman Ct. 21401 USA Funeral 11 Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: Black Widowed Divorced Yes. Give Yea 1 Yes 2 X No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Annapolitian should be filed within 72 is marked other than " atic event, the Medical Baltimore, MD 21215-0036 11th Nursing Assistant Assistant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be umatic event, Sylvester Davis Fannie Mae Lawrence ပ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Sheppard(Son) 421 Harbrook Place Annapolis, Md. 21403 it of Health ar at: If item 2 Pages 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 1-10-07 Important: injury or oth Annapolis, Md. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 2Whine arkeese FacilitySons Mortuary, P.A. MOC483 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21401 **Physician** failure. List only one cause on each line Between Onset and /Medical a Hip and Leg Injuries with Complications Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED physician the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 🗸 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page Yes 2 V No Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes ٥ 28a. Date of Injury (Month, Day Year) Dec 30, 2006 After 27. Manner of Death 28b Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Passenger auto auto collision Natural 0526 hrs Director: d in by the f 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Jennifer Road & Admiral Drive, Annapolis, MD determined (Specify) Local Street To the Funeral 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. January 3, 2007 rass 17 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

			State of Maryland / Department of Health and Mental Hygiene Contificate of Death	06
			Reg. No.	-
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 130	
	/Medic		vincent digitary	FIM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location ol Death 4c. County of Death	
			CITIZENS NUISING HOME HOVED & GOOD HOVED OF Social Security Number 6. Sex 7. Age (In vis. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthdage (State of	
	Funeral		Months Days Hours Min. (Month, Day, Year) Country)	r Foreign
	Director	ļ	220-76-1062 123 M 2 L F 90 Yrs. World State Jun. 22, 1916 Maryland	
	land		10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit	ty Limits
	Mary -f sh	tor	MD Harford Havre De Grace ¹□Yes	2 No
	288	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	3a o	0	415 South Market Street 21078 USA	
	death with the Maryland ms 23a or 28a-f show rount be retified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
	affe affe	Ē	1 X Never Married 2 Married 1 ☐ Yes 2 X No	
	Pal', c	l by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify: White Specify: White	
· ·	5-0 72 ha	etec	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working	
7	전 를 을 돌	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	
3	Med w		n/a n/a Never worked Handicapped	
	tral H had out	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
•	Maryland 21215-0036 nd 2 should be filed within 72 hours after dea that and Mental Hygiene. 27 is marked other than "natural", or Items traumatic event, the Medical Examination	ပ္	Joseph Digiorgio Rosalie Domina	
- 4	Mai 12 st h and 7 ts n rraun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	e, lealt and lealt lealt ther ther		William DiGiorgio - Brother 311 Willrich Circle, Unit M Forest Hill MD 21 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition 20b. Place of Disposition 20c. Location - City or Town, State	.050_
	IOC Iges or o		1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place)	
	Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If Item: any injury or other		'4 Donation 5 Other (Specify) Metro Crematory Jan. 9, 07 Baltimore, MD	
í	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and the recitifical and once.		21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228	
			23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	ween
	Physician		Immediate Cause (Final disease or condition Onset and D	eath
	/Medical		resulting in death) Due to (or as a consequence of):	
T	Examiner		Sequentially list conditions, b.	
<u>C</u>	A D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
2 12	cords, P.O. Box 68760, &	Examiner	resulting in death) Last Due to (or as a consequence of):	
C 's	760, te be exe	caiE	230 (0 (0) 43 4 03) 1304001 (38 01).	
5	687 tificate g physi as the l		d.	
	ox 68 certifica nding ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	
0	Box sath cert attendin for use	Physician/Med	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Y	'ear
3	P.O.	ıysi	1 Yes 2 No 9 Unknown 9 Unknown	
	that the ed by deta	/Ph	Part II_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	ea(h?
ŏ.	ecords, P.O. BG law requires that the death as been signed by the atter t 2 should be detached for u	d by	1 Yes 2 No 3 Probably 4 U	Inknown
3	w req	lete	WING 24a. Was an 24b. Were autopsy findings a	available
5.	Rec	Completed	adupty prior to completion a death?	iuse of
	Vital F sician: Th certificate rector, pag		25. Was case referred to medical 26. Place of Death (Check only one)	
	Vital sician: T s certificat lirector, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	
`	Division of I or Attending Phy after death. Director: After this in by the funeral d	-	27. Manyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	_
	nding nding tth. :: Afte	ation	1 VNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
	Atternation of the by the	iffice	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office 28l. Location (Street and Number or Rural Route Number)	ber,
i	Div al or al Dir	Certification;	4 Homicide building, etc. (Specify) City or Town, State)	
	Division of Vital Record to the Hospital or Attending Physician: The law requir within 24 hours after death. to the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should		29a. Certifier (Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	in 24 he Fi plete	edical	one) and manner stated.	
	o the com	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			11 741/4 M.1). 1140 412 1/8/0"+	
	4		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	
			Ac sup sin 319 si culion for 100 mg 2018	
	Sta Registr		31. Date filed (Monn, Day, Year) 32 Registrar's Signature	
	lnegisti	GI .	John John John John John John John John	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per 1h 8663 1-9-07 vt. State of Maryland / Department of Health and Mental Hygiene 17 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 3:16 PM Annette D'Antonio Catherine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale E If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 16 (Month, Day, Year) Baltimore Franklin Square Hospita 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F Months 214-26-9461 Usual Residence of Decedent Yrs. Director Maryland July 26. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ehow. ir then "netural", or Iteme 23a or 28a-f eho The Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Perry Hall Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3750 Proctor Lane 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F George Jackmore Anna Marie Eid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Heelth : If item 27 i Gina T. D'Antonio (daughter) 439 E. Fort Ave. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dai:007 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny Injury or once. 1/9/2006Bayview Crematory Baltimore, Maryland McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, MD 21230 21. Signature of Funeral Service Licensee J. Wayne Osterling 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infache **Physician** Acrte mysendal hon /Medical **Examiner** Arten Dixease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 60100 Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien at s the burial-t Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Hunknown Hypertenson 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 1 Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a filled 29a Certifier Constyling Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certifie

Registrar

31. Date filed (Month, Day, Year) JAN 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Greenwald, 9000 Franklin Square Drive, Baltimore, M. D. 32. Pogistrar's Signature

D0054670

06,2003

eri

5

antonio

Maryland 21215-0036

timore,

Box 68760.

P.O.

Division of Vital Records.

		For State Registrar	te of Maryland / Depa <i>Ce</i> l	artment of Hertificate of E			ene 007	00208
Physicia /Medic			YWALT			2. Date of Death Month January	Day 799 of 100 o	2:15AM M
Examine Funeral Director	er	4a. Facility Name (If not institution, give street at 8309 Patapsco Road 5. Social Security Number 219-64-8113 6. Sex 1□ M 2 21	7. Age (In yrs. last birthday)	Pas If Under 1 Year Months Days	adena If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, y June 08,	4c. County of Dea Anne Anne Anne Anne Anne Anne Anne Anne	
r 28a-1 ehow	Director	Usual Residence of Decedent 10a. State 10b. County	el Pasadena			10g	ı. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🗷 No ountry?
offier death v	Funeral	1 Never Married 2 Married 1 If Ye	Yes 2 No	Was Decedent of His if Yes, specify Cuban	1122 spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Am Black, Whi	
yland 21215-0035 uld be illed within 72 hours af Mental Hygiene. arked other than "natural; or atte event, ine Madical Event	Be Completed by	15. Decedent's Education (Specify only highest grade complete of the complete	eted) (Give life. i	dent's Usual Occupat kind of work done di DO NOT use retired) egistered	Nurse	ing e (First, Middle, Ma		
Baltimore, Maryland 2 Permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygie Important: if Item 27 is marked other tany Injury or other traumatic event. In DOG.	₽	19a. Informant's Name/Relationship (Type, Prin William E. Daywalt Sr 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundam Service Licensee	(Husband 830 from State 20b. Place of Dispo	matory or other place Mem Park Name and Address	o Road,	Pasadena, Date 20	City or Town, State, Maryland c. Location - City or kesville,	l 21122 Town, State Maryland
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. Do not ent on each line.	Cully-Pol 04 Mounta er the mode of dying,	yniak fu in Road, such as cardiac o	neral Hom Pasadena or respiratory arrest	e P.A. , Marylar	Approximate Interval Between Onset and Death TWO YEARS
the death certify the ettending ched for use as	Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)		71.*	23d. Date of de Month	livery Day Year
requires the sear signer signer the signer s	Completed by P	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause giver	n in Part I.		pacco use contribute to the cause of death? ps 2 □ No 3 □ Probably 4 ★Únknown	
The The page	ne Com	25. Was case referred to medical examiner?			26. Place of Death	autopsy performed 1 ☐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
Phys ral dir	Certification; 10	1 Yes 2 No Hospital: 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatien Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury a Work? M 1 \sum Ye	at ses 2 No	28d. Describe how		
		4 Homicide determined 209. 29a. Certifier 12 Certifying Physician: 1	Place of Injury - At home, farm, stre building, etc. (Specify) to the best of my knowledge, death	occurred at the time	date and place	City or Town, S	e(s) and manner as	estatod
To the Ho within 24 P	Medical	Consect only 2 Medical Examiner: On	the basis of examination and/or invitation and/or invitation.	29c. License (D 439	nion, death occurri number	ed at the time, date	and place, and due Date signed (Mont	to the cause(s)
State Registra	9	30. Name and address of person who completed DWI H TM D 31. Date filed (Month, Pay, Year)	cause of death (Item 23a) (Type, 122 ST	Print) LIL PLA	CE BA	ict imar	E MI)	21202

DHMH 17 Rev 1/2001

			For	State of Maryland /			Mental Hygie	ne	
			State Registrar	-:	Certificat	e of Death	Reg.	No. 2 9 9 7	3 Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Later LEROY CHARLE)	S ENGLE			JANUARY	Day Year 200	7 07:00AM
	Examin		4a. Facility Name (If not institution, giv Saint Joseph	e street and number) Medical Cente	4b. City,	Town, or Location of Death			timore
	Funeral Director		5. Social Security Number 213-68-1377 6. S	ex 7. Age (<i>In yrs. last t</i> 49	Yrs. If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth August 21	9. Bird	hplace (State or Foreign Protyland
and other	nd.		Usual Residence of Decedent 10a. State 10b. County	10c City To	wn or Location				10d. Inside City Limits
	Maryla a-f shov ified at	tor	MD B		Perry Hal	.1			1 □ Yes 2 No
	th with the 23a or 28 st be not	al Dire	10e. Street and Number 9210 A Snyder L	ane	10f. Zij	21128	10g	. Citizen of What Co USA	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatils and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
1215-0036	within 72 ho ene. than "natur ne Medical i	Completed	15. Decedent's E. (Specify only highest grant properties) Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5+) Tilde Completed (1-4or 5+)	Sa. Decedent's Usu (Give kind of wo life, DO NOT u ire appar	ial Occupation ork done during most of work se retired) catus driver/	operator 16	b. Kind of Business, altimore (Fire Depa	County
and 21	id be filed vental Hygie ked other ic	To Be Co	17. Father's Name (First, Middle, Last	orth Engle, Sr			ne (First, Middle, Ma Helen Kl		L
Maryland	nd 2 shou alth and M 27 is marl r traumati	-	19a. Informant's Name/Relationship (Denise Engle-s		9b. Mailing Addres 210 A S	s (Street and Number or Re ynder Lane-	ural Route Number, C -Perry Ha	City or Town, State, . all, Mary	Zip Code) land 21128
Baltimore,	Pages 1 a lent of Hea nt: If item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State EVANS	of Disposition (Na FUNERAL TOTAL TON SERVICE	PEL'AND Jan		c. Location - City or Forest I	Town, State Hill, Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee f	22. Name a	nd Address of Facility FUNERAL CHAP FMATION SERV	ICID		Road aryland ²¹²³⁴
,	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death. Done cause on each line. RESPSIRATOR			c or respiratory arresi	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence REFRACTORY		10			
Š	*	iner	Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence					
68760,	icate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
O. Box 68	sath certifi attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic;			23d. Date of de Month	livery Day Year
Δ.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying	cause given in Part I.	23e. Did toba	1/	o the cause of death? robably 4 □Unknown
Recor	et o oi	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
tal			25. Was case referred to medical			26. Place of De	1 Yes 2 ath <i>Check onl one</i>	No 1 ☐ Yes	2 2 110
Ž	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 D	OA Other: 4 Nursing I	Home 5 ☐ Residen	ce 6 □Other (Spe	ecify)
0 u	ding Ph n. After th funeral	T :uc	27. Manner of Death 1 W Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Division or Vital Records,	Attend death cctor; y the	Medical Certification:	ACcident investigation 3	De 280 Place of injury - At home	M , farm, street, facto	1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory (completely filled in b	dical C	29a. Certifier (Check only one) 1 Certifying P Medical Exa	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurre and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	"	29	9c. License number	290	d. Date signed (Mon	th, Day, Year)
	177		30. Name and address of person who	a completed cause of death (Item 22	a) (Type Print)	D37254		18 (0	1
	12		BOON POH LIM,		SLER DRI	VE TOWSON	, MARYLAN	ID 21204	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		-			

07-00164 Marie Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day January 6, 2007 Medical Examiner Marie M. Evans 1505 hrs 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7001 N. Charles Street **Baltimore County** 9 Birthplace (State or Foreign Maryland 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY **Funeral** Months Davs Hours Min Director 2 X F 81 6/19/1925 219-16-7719 М Country) Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County X Yes 2 No Baltimore Baltimore or 28a-f show MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygues in east. If them 27 is marked other than "natural", or items 23a or 28a-f sho and it. If them 27 is marked other than "natural" nor items 23a no 28a-f sho nor for transmatic event, the Medical Examiner must be notified at once. Director 10e Street and Numbe 10f. Zip Code 10g Citizen of What Country' 21206 USA 3403 Pinewood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funera 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? Never Married White XX No Yes 1 Yes XX No specify 3X X Widowed 4 Divorced If Yes, Give Year Specify þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Residence Homemaker 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Francis Wafer Helma Marie Hoesl 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Janice M. Sachs/ daughter 3502 Glenmore Ave. Baltimore, MD 21206 20a Method of Disposition 20b Place of Disposition (Name of cemetery 20c. Location - City or Town, State January crematory or other place) 1XX Burial 2 Cremation 3 Removal from State Lorraine Park 12, 2007 Baltimore, MD Donation 5 Other Specify: 22. Name and Address of Facility Evans Funeral And Cremation 8800 Harford Parkville 21234 21. Signature of Funeral Se Rd. Chapel Services omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her on each line Acute pneumonia with atherosclerotic cardiovascular disease Enter the disease, or complications Approximate Interval **Physician** ailure. List only one cause Between Onset and /Medical Death Acute meaning with athersecleratic cardiovascular Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical #23a,perm,E G864, 2/21/07 X UNPENDED g physician a the burial -#23a,27,perM,E g864. Division of Vital Records, P.O. Box 68760, IE FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Fetal death Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Completed by Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? . death? ✓ Yes 2 No. 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) fo the Hospital or Attending Physician: Be Hospital: 1 Other₄ Inpatient DOA Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 28a Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: within 24 hours after deam

To the Fineral Director: A 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c License number 29d Date signed (Month Day Year) O.C.M.E January 7, 2007 U 30. Name and address of person who completed cause of death (Item 23a) Ö 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the mosphers after death.

Within 24 hours after death.

To the Funeral Director: Af

Baltimore, Maryland 21215-0036

Certification: To

Medical

State Registrar

29a. Certifier (Check only

6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2007

29b. Signature and title of certifier 29c. License number

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheldon M MO GOOD SAMAKITAN HOSPITAL

31. Date filed (Month, Day, Year)

JAN 09



9+1

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I			giene 0 0	7 00212
	975	荡	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physicia /Medic	- 2	Margaret M. Fer	rrell				Januar	- '	
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Dea	th	4c. County of	Death
			Manor Care Potomac			Potoma			Montgo	
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month. Da	v. Year)	Birthplace (State or Foreign Country)
المينان.	Director		121-36-4196 Usual Residence of Decedent	-A	98 Yrs.			Aug. I	1, 1908	New York
	land If		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh ijedu	ţ	New York Orange		Highland	Falls				1 ∑Yes 2 □ No
	r 28a	Director	10e. Street and Number		1128-124114	10f. Zip Code			10g. Citizen of Wh	nat Country?
	h with	O E	82 Roe Park			10928			U.S.A.	
	deati	Funerai		2. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of I	tispanic Origin? (S	Specify Yes or No	. 14. Race	- American Indian, , White, etc.
ထ္	or its		1 Never Married 2 Married	1 ☐ Yes 2 💢 N	lo	1 ☐ Yes 2 ☒ No		no i noari, oro.,	Specify:	, willie, etc.
8	ural',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:						White
<u>7</u>	nati	Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edent's Usual Occu e <i>kind of work done</i> DO NOT use retire	during most of wo	orking	16b. Kind of Bus	iness/Industry
12	withir	d L	Elementary/Secondary (0-12)	College (1-4or 5	+)	omemaker	0)		Own Ho	am o
2	Hygie ther int, #		17. Father's Name (First, Middle, Last)	2	П	memaker	18. Mother's Na	me (First, Middle,	Maiden Sumame	
an	ontal ed b	o Be	Jacob L. Hicks					es Hager		•
<u></u>	shoul mark mark	오	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mail	ing Address (Street			er, City or Town, S	tate, Zip Code)
\leq	od 2 silth ar		Suzanne M. Nichola		hter\ 1130) Doswood	Dr. Mc	Lean, VA	22101	
Baltimore, Maryland 21215-0036	s 1 au f Hea item othe		20a. Method of Disposition		20b. Place of Disp			Date		ity or Town, State
Ë	Page sent c int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metropol:			9/07	Alexandr:	ia. VA
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperminent of Heatil and Mental Hygiene. Deperminent of Heat and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marylan Examinar must be multiped at once.		21. Signal re of Funeral Service License	1)		2. Name and Addr Villiam F	es of Facility			
Ω	8923		Lennis (Willnes	un	135 Main	St. Hig	hland Fa	lls. NY	10928
e :			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Can	diac a	grilly	thru	ia		Onset and Death
208	/Medical Examiner		resulting in death)	Due to (or as	diac a consequence of):		1			
Е	LAdiffile	_	Sequentially list conditions, b	A)	rial f	ihvil	lahan			
	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence on:					
_	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last		a consequence of):					
8760,	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	alE								
687	ificate g phy as the	Physician/Medical								
Вох	leath certific; attending pl	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date	of delivery
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnanc □ Other <i>(specify)</i> _	У		Mont	h Day Year
P.O.	thet the de ed by the detached	hys	9 Unknown	9□ Unknown						
S,	es the igned be de	by F	Part II. Other significant conditions con	-	4	underlying cause gr	ven in Part I.		_	oute to the cause of death?
ord	w requir been si should		HOVAUUO	De mei	140			101	Yes 2□No 3	Probably 4 Nunknown
ecc	law r las be	Completed						24a. Was autop	osy pr	ere autopsy findings available for to completion of cause of
	iician: The la certificate has rector, page 2	ő						perfo		ath? ☐Yes 2,⊠No
Zita Zita	cian	Be	25. Was case referred to medical examiner?	ospital:				eath (Check only o	one)	
o	Phys this al dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		HIL 3L DOA			dence 6 Other	
o	ding h. After fune;	tion	1 Natural 5 ☐ Pending	(Month, Da)	Year) Injury	Wo	rk?]Yes 2 □No	20d. Describe i	now injury occurre	
Division of Vital Records,	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, s			28f. Location (S	Street and Number	or Rural Route Number,
á	el or A s efter I Dire	Certification:	4 Homicide	building, etc	c. (Specify)			City or Tox	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier LK Certifying Phys (Check only 2 Medical Examin	ician: To the best of	of my knowledge, dea	th occurred at the t	me, date and place	e, and due to the	cause(s) and man	ner as stated.
	the H	ledical	one)	and manner sta	ited.					
	To the I	Σ	29b. Signature and title of certifier	200		29c. Licen			29d. Date signed	(Month, Day, Year)
,			19	<i>1</i>			54566		11910	+
C			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	, Print)	1 (21.70		MD21266
920	Sta	10	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Je gra Re	ed, il	111230	DWION	19121216
***	Registi		IAN 0 9 200	45	J. B. A.	make !				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Arberry 11:00 AM Fowlkes FOOD 7 January /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimorr Randallstown Nontemest Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 18 M 2□F Months 13-40-5655 VIRGINIA Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medicial Exercitant the confilted at 1 Yes 2 □ No Director NIA MARVLAND 10g. ditizen of What Country? 10e. Street and Number 10f. Zip Code 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nanje/Relationship (Type, Print) ROL Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition place 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN 22. Name and Address of Facility BROWN 21. Signature of Funeral Service Licensee FUNERAL HOME once. FULTON AVE, Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Reval End Stage Discos-P /Medical Due to (or as a consequence of): Examiner pentensic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Cereloval Vasce the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death **95**0 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year should be detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 🗷 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 1 Yes 1 Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2K ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier are W 140055644 V 2007 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown Hospital 5401 Northwest 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

07-00075 Jerry Joe Ferguso		Please Type or Print in Black Indelible Ink. Ensure All C State of Maryland / Department of Health and Men Certificate of Death	ntal Hygiene	2007	0021
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De		Time of Death
Medical Examin	er	Jerry Joe Ferguson Jr.	Month January		1100 hrs
بالرطيقي		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 17C 9th Street Glen Burnie	of Death	4c County of Death Anne Arundel	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und		Birth(MM/DD/YYYY) 9 Birthp	place (State or
Director		579-98-8617 1Xm 2 F 39 Yrs Months Days Hour	s Min. April	. 23,1967 Foreign Coun	ntry) DC
any		Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
*	_	MD Anne Arundel Glen Burnie			1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number 10f. Zip Code		10g Citizen of What Countr	y?
h the N		17C 9th Street 21061		U.S.A.	
ath wit items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori		No- 14. Race - America White, etc.	an Indian, Black,
fter de	〗	1 Yes 2 X No 3 Widowed 4 X Divorced liftes, Give Year 1 Yes 2 X No specify	ľ	Specify: Whi	te
hours a	ed by	Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business/Ind	dustry
36 nin 72 E. Ilan "dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Painter		Construct	ion
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	하	17. Father's Name (First, Middle, Last)	er's Name (First, Middle	e, Maiden Surname)	
121 d be fil lental P arked	Be	, , , , , , , , , , , , , , , , , , , ,	ta Silvas		
MD 21 d 2 should 1 th and Mer n 27 is mar aumatic ev	은	19a Informant's Name/Relationship (Type, Print) Mrs. Anita Ferguson / Mother 5922 Woodfield Es			
e, N l and 2 Health item 2	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Jan.8,	20c. Location - City or To	
mor Pages ent of int: If		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Resurrection Cem.	2007	Clinton, M	ID
Baltimore, permit Pages I an Department of Hea Important: If iten	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facilit			
Physician	-	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as		Burnie, MD 21	061 Approximate Interval
/Medical		failure-List only one cause on each line. Immediate Cause (Final disease a. Heroin intoxication	, -		Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of).			
to any part of	ا <u>ة</u>	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Unsease or injury that initiated			
uted did		events resulting in death) Last Due to (or as a consequence of): d.			
, ne execute cian and rial - trar	dica	X UNPENDED #1,23a,PII,27,28a-f, perME, G863	1/25/07 TT		
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be execut redeath ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - tran		IF FEMALE 23c. If yes, outcome of pregnancy	pic pregnancy	23d. Date of delivery	Vans
x 68 th certification	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	nc pregnancy	Month Da	y Year
be deal	3	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Port I 23a Did	tobacco use contribute to the	a source of death?
b, P.O. irres that the signed by t	δ	Cocaine use		es 2 No 3 Probab	
ords, w require us been si should b	Completed		24a. Wa		psy findings available
ecor ne law te has l	dmo		per	formed? prior to cordeath? s 2 No 1 Ves	npletion of cause of
Vital Records hysician: The law requi this certificate has been all director, page 2 should	a)		h (Check only one)	7 2 10 10 103	
of Vital Records, ig Physician: The law requir the this certificate has been shern ineral director, page 2 should	일	examiner? 1 V Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other4	Nursing Home 5	Residence 6 🗸 Other: S	Scene
n of Noting Physics After the funeral		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending TNJ 1/2/2007 Food 10-20 and 1 Yes 2 X	7 No.	e how injury occurred	
Division al or Attendi rs after death al Director: led in by the fi	ertification:	2 Accident Investigation PNU 1/3/200/ PNU 10:30 all 28e. Place of Injury - At home, farm, street, factory, office building e	etc. 28f. Location	ı (Street and Number or Rura	I Route Number, City
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Certif	Suicide Suicide determined (Specify) found at home		, State) 17 C 9th St	reet
To the Hosy within 24 hor Coupletely f		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and prone)			
To this comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of certifier 29c License number		29d. Date signed (Month	
		Oct. Ass. i Polose o.c.m.e.		January 4, 2007	, = ay. (car)
	}	30 Name and address of person who completed cause of death (Item 23a)			

31 Date filed (Month, Day, Year) JAN 0 9 2007 State Registrar

Patricia Aronica-Pollak MD.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature

Box 68760. P.O. Records, Division of Vital

An

5

Funeral

Director

other then "natural", or items 23s or 28s-f ehor vent, the Madical Examinar must be notified at

ö

"natural",

7 is marked othe treumatic event.

permit. Pages 1
Department of H
Important: if ite
eny injury or oti

Physician /Medical

and 2 should be teelth end Mental

Baltimore, Maryland 21215-0036

04,

Thruany

Examiner physicien s the burial Hospital or Attending Director: / within 24 hours a To the Funeral C

> State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Julen

29b. Signature and title of certifier

30. Name and add



ed cause of death (Item 23a) (Type, Print)

738 Greene Tree Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 56 AM COURSE Lobin Januaru 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. January 9, Birthplace (State or Foreign Country)

Maryland

Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 215-02-7839 1 □ M 2 🕱 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Dundalk Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or USA 21222 100 Maryland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 🎾 No Specify: White Specify: Completed by 3 Widowed 4 Divorced r than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than "ry traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) Printing Apparel Screen Printer 12 years 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othn any Injuy or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Kathleen Chaney James Gorski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Maryland Avenue, Dundalk, Md. 21222 Kathleen Hockenbrock Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1X Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery Dundalk,MD. 9, 2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. mith 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ly only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò protein mainumnian, 1 Tes 2 No 3 Probably 4 Unknown Type Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

be executed Box 68760, P.0. Division or Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holley Dr Abigail 3 Registrar's Signature 31. Date filed (Month, Day, Year)

4940 Eastern Nenue Baltimore, 140 21224

29d. Date signed (Month, Day, Year)

January

2007

Registrar

Duligail Hollis MD

29b. Signature and title of certifier

29c. License number

RES-000

Eddie Golf 07-00049

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

NK UNK		State of Maryland / Depar 1-For State Cert	tment of Health and Ivlent ificate of Death	Reg. No. 20	7 0021
Physicia		Recistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3 Time of Death
Medical Exami		Eddie	Golf II	January 2, 2007	1526 hrs
Mineral J		Facility Name (if not institution, give street and number) 4900 Block Challedon Road	4b. City, Town, or Location of Baltimore	of Dealin 40. County of De	am
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. last	′′	er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9.	Birthplace (State or eign
Director		220-94-4326 1XM 2_F 26	Yrs. Months Days Hours		Country) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or Location		10d Inside City Limits
* .	ě	MD NA Ba	ltimore		1 X Yes 2 No
Maryl: r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	•
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	a D	2853 West Garrison Ave 11. Marital Status 12. Was Decedent Ever in U.S	21215 13. Was Decedent of Hispanic Orig		nerican Indian, Black,
leath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican,		
	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify:	Black
21215-0036 uld be filed within 72 hours after Mental Plygiene marked other than "natural". c event, the Medical Examiner	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a, Decedent's Usual Occupation (Give I during most of working life. DO NOT		ss/Industry
D36 thin 72 ne than edical	Completed	llth grade na	Baker	Ms. Dess	serts Co.
5-0(iled wi Hygier I other		17. Father's Name (First, Middle, Last)		's Name (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	To Be	Eddie J. Golf Jr. 19a Informant's Name/Relationship (Type, Print)		dora Henley nber or Rural Route Number, City or Town, St	ate Zin Code)
ore, MD 21218 cs I and 2 should be fil of Health and Mental F If item 27 is marked ther traumatic event, 1		Pandora Smallwood-Mother		ison Ave, Balto, M	
re, re land f Healt f Healt f item	İ	20a Method of Disposition 20b P	lace of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - City	or Town, State
_ G # # 6		4 Donation 5 Other Specify		1/10/07 Baltimon	ce, Md
Baltir permit. P Departme Importa		21 Signature of Funeral Service Licensee	22 Name and Address of Facility March F/H We	st	1d 21215
Physician	-	23a. Parti. Enter the disease, or complications their caused the death.	Do not enter the mode of dying, such as c	Ave, Baltimore, A ardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medical Examiner	8 3	failure. L'ist only one cause on each line. Immediate Cause (Final disease a Asphyxia, Blunt Force al	nd Multiple Gunshot Wounds		Between Onset and Death
LAGITITIET		or condition resulting in death) Due to (or as a consequence of)	i.		
Same and the same	ř	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	:		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Under the Company of the Compa	Y		_
cuted cuted transit			*-		
760, Acate be executed physician and he burial - transit	Medical	UNPENDED AMENDED			
x 68760 th certificate b ttending physi r use as the bu		23b. Was decedent pregnant in the		23d. Date of delive pregnancy Month	rery Day Year
Box 687 e death certifice the attending p		past 12 months? 1 Yes 2 No 9 Unknown 0 Unknow			
b.O. Be that the de red by the detached f	Phy	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Pa	art 1 23e. Did tobacco use contribute	to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that that that the reder death. The intercent After this certificate has been signed by led in by the funeral director, page 2 should be detact	d by			1 Yes 2 No 3 P	robably 4 Unknown
ords, F w requires s been sign should be	Completed			autopsy prior t	autopsy findings available to completion of cause of
Reco The law cate has	Com			performed? death 1 ✓ Yes 2 No 1 ✓	process.
Vital Recysician: The l	Be	examiner?	26 Place of Death	·	
1 of Vi ling Physi After this funeral did	. To	1 V Yes 2 No	ER/Outpatient 3 DOA Other 4 28b. Time of Injury 28c Injury at Work	Nursing Home 5 Residence 6 ✓ Ot ? 28d. Describe how injury occurred	ner. Scene
ion creating leath tor: Af	ıtion	1 Natural 5 Pending FOUND: 2 Accident Investigation Jan 2, 2007	FOUND: 1 Yes 2 🗸	Subjected assaulted	
ivisior or Attencather death Director:	Certification:	3 Suicide 6 Could not be 28e Place of Injury - At ho	me, farm, street, factory, office building, et	or Town, State)	
Dj ospital bours a meral I y filled	Cer	4 Homicide determined (Specify) Woods 29a. Certifier 1 Contifuing Physician: To the best of my knowledge		4900 Block Challedon Road, Bal	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	Medical	Check only one) 2 Medical Examiner:On the basis of examination and			
To To	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A.		Lard Halla	O.C.M.E.	January 3, 200)7
9		30. Name and address of person who completed cause of death (Item Carol Allan, MD Assistant Medical Examiner	^{23a)} 111 Penn Street, Baltimore, MD	21201	
	tate	100/78			
Regis		29	(poste)		
DHMH 17 Rev 1/2	2001		ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

		For State		State of Ma	ryland		rtment of H						00218
		Registrar	ne (First, Middle, La	st)		Cei	incate or i	Jeani		2. Date of De	Reg. No.		3. Time of Death
Physici		Ranj								Januai	cv 6	, 2007	7 5:45 A M
/Medio				e street and number)			4b. City, Town, or	Location			_	County of Dea	
		Ruxton H	lealth & R	ehab of Pil	kesvi.	lle	Pikesvil					1timore	
Funeral Director		5. Social Security I 161–46–		ex 7. Age	(In yrs. las:	t birthday) Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir Month Di AUG 21	th ay, Year) 19	43 9. Bir	thplace (State or Foreign ountry) 1 a
ъ		Usual Residence of	of Decedent		-			L					
arylan show d at	Ļ	10a. State	10b. County			Fown or Loc	ation						10d. Inside City Limits 15€ Yes 2 No
he Ma 18a-f otifie	ecto	MD	N/A		Balti	more	10f. Zip Code				10a Citi	zen of What Co	
with t a or 2 t be n	흐	10e. Street and Nu	Calvert S	÷			21218				USA		oundy:
death ems 23 r musi	Funeral Director	11. Marital Status	Carvert	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu		rried 2 Married 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:	0		☐ Yes 2√ No	Specify				Specific	ian Indian
2 hou satura		/0	15. Decedent's E			16a. Deced	ent's Usual Occup	ation	et of work	ina	16b. Ki	nd of Business	
ithin 7 ne. nan "n	Completed	Elementary/Sec	condary (0-12)	College (1-4or 5+		life. E	OO NOT use retired	dining mo	St Of WORK	ny	0-16		٠
iled w Hygiel Ther th		17 Father's Name	e (First, Middle, Last	5+	C	onsul	tant	18. Moth	ner's Name	(First, Middle		Employ Surname)	/ea
d be fi	Be c	Bimal Gh		,						a Dutta		<i></i>	
shoul nd Me mark	٦		Name/Relationship (Type. Print)		19b. Mailin	g Address (Street					r Town, State,	Zip Code)
and 2 ealth a m 27 is		Elsa Gho	sh/Wife				N. Calve		St Ba	ltimore			
Pages 1 nent of He int: If Iten		20a. Method of Dis		Removal from State			sition (Name of natory or other place			Date		ocation - City or	
nit. Parantmen			5 Other (Special Service Lice	y) 15ee C. Todd			matory, II . Name and Addre		1/6/9			imore,	MD
permit. Departr Importa any Inju		<i>C</i> :	Tall 7	/		2	Name and Address remation 99 Frede	rick	Rd B	altimor	e. M		3
* *		23a. Part1. Enter shock, or he	the disease, or comeant failure. List only	plications that caused one cause on each line	the death. e.	Do not ente	er the mode of dyin	ig, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause disease or conditi resulting in death	ion	a. Due to (or as a	sep.	515							DAYS
/Medical Examiner		3			l consequer								months
	Jer	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease of	conditions, immediate	b. Due to (or as a									
Scuted Ind	Examiner	Cause (Disease of that initiated even resulting in death)	IS III	C									
cate be executed physician and the burial-transit		resulting in death)	Lust	Due to (or as a	i consequer	nce or):							
ficate physis the	edical			d									
death certifice attending ph	In/M	IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, outcome p	of pregnance	y eath 3	Ectopic pregnancy	,				23d. Date of de	
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 □ No	4☐Pregnant at			Other (specify)	<u>'</u>				Month	Day Year
that the				contributing to death bu	t not resulti	ng in the ur	iderlying cause giv	en in Part	t.	23e. Did	tobacco i	use contribute t	to the cause of death?
quires n sign	d by	(0)								10	Yes 2	□No 3□P	robably 4 Unknown
aw rec	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
The The sate he	E O									perf 1□ Yes	ormed? 2 No	death?	
VILC Ician: Sertific ector,	Be	25. Was case refe examiner?		Hospital:			Oth			n (Check only			
Phys this or	2	1 ☐ Yes 2	No	1 ☐ Inpatier		R/Outpatien 8b. Time of		4 /4 I N		me 5 Res 28d. Describe		6 □Other (Spe	ecify)
rh.: After	tion	1 Natural 2 Accident	5 ☐ Pending investigatio	(Month, Day	Year)	Injury	Wor	k? Yes 2∐				,, 000000	
r Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined			e, farm, str	eet, factory, office			28f. Location (Rural Route Number,
pital o		29a. Certifier	1 ortifulna D	nysician: To the best o	of my knowl	edae death	occurred at the ti	me date s	and place	and due to the	causals	and manner a	es stated
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only	2 ☐ Medical Exa	miner: On the basis of	examinatio	n and/or in	vestigation, in my o	opinion, de	eath occur	red at the time	, date an	d place, and du	e to the cause(s)
To th withir To th	Me	29b. Signature a	nd title of certifier	4 100			29c. Licens	e number	77-		29d. Da	te signed (Mon	th, Day, Year)
•				7		n-1 /T	<i>V5</i>	OK	7		JAA	VARY G	o. W
5		30. Name and ad	dress of person who	completed cause of de	701	N W	alles ST	BO	nma	re wo	24.	204	
	ate	31. Date filed (Mo	onth, Day, Year)	32. Régistra	r's Signatu	re	and I					7	
Regist	2001		MULIA A A	001	Fred Street	es de la constante de la const					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:20 P M Pearl R. Gellerstein Jaunuary 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Milford Manor Nursing Home Pikesville Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. FEB 9, 088-03-1937 New York 1915 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrem any lipiny or other traumatic event, the Mention Event. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No Director Baltimore MD Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 4204 Milford Mill Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gellerstein Barnett Fanny Resnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Gittlen, cousin 7009 Plymouth Road Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/09/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2,5 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this illed in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

5 State 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Karen

Karen L. Belett, M.D.

L. Babitt

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID.

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001 29c. License number

110058676

25 Main street suite 200 Reinterstown MD 21136

29d. Date signed (Month, Day, Year)

January 9, 2007

			For State Registrar	State of Maryland	-	artment of F			Reg	ene . Ne2 0 0 7	00220
	Physicia		1. Decedent's Name (First, Middle, Last)	ENSLER	SR.			N	ate of Death Ionth	Day Year 4 2007	3. Time of Death 6: 16A M
<i>\</i>	/Medic Examin		4a. Fecility Name (If not institution, give stre Union Memorial Ho 5. Social Security Number 6. Sex		act hirthday	4b. City, Town, o Balti If Under 1 Year	more_	of Death	ate of Birth	4c. County of Dea	th thplace (State or Foreign
	Funeral Director			^{2□ F} 63	Yrs.	Months Days	Hours	Min. Oct	Aonth, Day, Y	ear) C	aryland
	Maryland	tor	10a. State 10b. County Maryland Anne Art		, Town or Lo	ocation Brooklyn	Park				10d. Inside City Limits 1 ☐ Yes 2 🐼 No
	ter death with the Marylan Iteme 23s or 28s-f ehow	Direct	10e. Street and Number 5420 Wasena Road			10f. Zip Code 212	225		10g	U.S.A.	ountry?
036	72 hours after death with the Maryland Insturel', or Iteme 23s or 28s-f ehow Jissi Exaciliar must be coliffed at	Completed by Funeral Director		Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 Ø No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No		gin? (Specify \ , Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	
21215-0036	- 20	ompleted	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	completed) Cottege (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most d)	t of working		Sb. Kind of Business	
Maryland 2	should be filed withir and Mental Hygiene. • marked other the umatic event, tra M	To Be C	17. Father's Name (First, Middle, Last) Adam E. Gensler			CR DIIVE			st, Middle, Ma ller	iden Sumame)	
	ad 2 lift i		19a. Informant's Name/Relationship (Type) Adam W. Gensler So	Print)						City or Town, State, K, Marylai	
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 图 Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	emetery, cre	osition (Name of matory or other place Crematory		Date 1- 09-0		altimore,	
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee	James		2. Name and Addre cCully—Pc 37 East P			ral Hom	me P.A. altimore.	Maryland 212
1	Physician /Medical Examiner	er	23a Part 1. Enter the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immodrate	tions that caused the death cause on each line. SEPSIS Due to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a)	n. Do not en						Approximate Interval Between Onset and Death
8760,	cate be executed physicien and s the burial-transit	Ical Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequ	uence of):						
P.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	□Ectopic pregnanc □ Other (specify)	у			23d. Date of de Month	livery Day Year
	quires that tl n signed by uld be detac	ρ	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	underlying cause giv	ven in Part I.				o the cause of death? robably 4 Unknown
al Records,		Completed							24a. Was an autopsy performe 1 Yes 2 fi	prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hos	pital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Ott	200	of Death Ch		ce 6 □Other (Spe	acity)
on of	Jing Afte fune		27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		28d.		injury occurred	,
Division	st or Attendii after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office			ocation (Stre		lural Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my kno r: On the basis of examina and manner stated.	wledge, dea tion and/or it	th occurred at the tinvestigation, in my o	me, date an	d place, and c th occurred at	due to the cau the time, date	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To ti To ti	Σ	29b. Signature and title of certifier Vagana	mu H.I).	AT2		146		Date signed (Mon	
	H		30. Name and address of person who com DRAGANA TOM		23a) (Type	Print) HEMUI	RIAL	- HUS			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Joertha					

			For State Registrar	tate of Maryla		rtificate of			ene g. No. 2 A A 7	00221
	Physicia	an	Decedent's Name (First, Middle, Last) MODD IC		CA	DV		2. Date of Death Month JANUARY	Day 2007 2007	3. Time of Death
V	/Medic Examin	al	MORRIS 4a. Facility Name (If not institution, give stre	et and number)	GA	Ab. City, Town, c	r Location of Death	L	4c. County of Deat	2:10 A M
			JEWISH CONVALESCE			BALTI			BALTI	
6x	Funeral Director		220-05-2701 A		37 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day) 04/07/19	9. Birti 919	nplace (State or Foreign untry) MD
	fand ow at		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD BALTIMO	RE	BAL	TIMORE				1 ☐ Yes 2 No
	with the	Director	10e. Street and Number	C DRIVE #C	207	10f. Zip Code	01000	10	g. Citizen of What Co	
	ns 236 must	Funeral	7203 ROCKLAND HIL 11. Marital Status 12.	Was Decedent Ever in			21209 dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	USA ican Indian,
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 💥 No if Yes, Give Year or Dates:	1	f Yes, specify Cub I ☑ Yes 2[X] No		Rican, etc.)	Black, White	WHITE
5-0	"natu dical	letec	15. Decedent's Educat (Specify only highest grade of	on ompleted)	I (Give	lent's Usual Occup kind of work done OO NOT use retire	during most of work	king 1	6b. Kind of Business/l	ndustry
712	withir piene. r than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		CER	u)		GROCERY	
Maryland 21215-0036	12 should be filec h and Mental Hyg r Is marked othe traumatic event,	To Be C	17. Father's Name (First, Middle, Last) JACOB		GAR	Υ	18. Mother's Nam	e (First, Middle, Ma		HAMANSKY
lary	2 should and he is mai		19a. Informant's Name/Relationship (Type.	,	I	•			City or Town, State, Z	
	1 and Health em 27		PEARL KRAMER / WI 20a. Method of Disposition			Sition (Name of natory or other pla			Oc. Location - City or	RE, MD 21209
ē	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval nom State		natory or other pla CEMETERY		3/2007	ROSEDALE,	MD
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Fureral Service bicensee			Name and Address			SON & BROS	., INC.
			23a. Part1. Enter the disease, or complications, or neart failure. List only one	ions that caused the de						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cluse (Final disease or condition resulting in death)	Coronan	1	in di	sasi			Onset and Death
	Examiner			we to (or as a cons	sequence of):	0815				
	p ±	ner	if any, leading to immediate cause. Enter Underlying	Uue to (or as a cons	equence of):	4- 0	1			
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	Duld	r disc	an		
68760,	ificate be executed g physician and as the burial-transit	edical E	d.	Diabet	s Mu	Ulin	8		_	
_	= D 0	Medi	IF FEMALE:							
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use an	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome pf pred 1□Live birth 2□Fe 4□Pregnant at time of	etal death 3 ☐	Ectopic pregnand Other (specify)	у		23d. Date of deli Month	very Day Year
P.O.	t the d by the	hysi	1 Yes 2 No 9 Unknown	9☐Unknown						
Ś	v requires that the de been signed by the should be detached	b	Part II. Other significant conditions contri	outing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to s 2	the cause of death?
Sorc	w requir been si should	Completed						24a. Was an		topsy findings available
Be	The lay te has age 2	omp						autopsy perform	prior to o	ompletion of cause of
/ita	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			1-		th (Check only one	1	2010
or/	Physic r this c ral dire	은	1 Yes 2 No Hos	pital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier	I SU DOA		ome 5 Resider 28d. Describe how	nce 6 Other (Spec	city)
ion	Attending Physician: r death. ector: After this certific. by the funeral director,	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,		Wo	rk?]Yes 2 □ No		v mjary occurred	
Division or Vital Record	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical (ian: To the best of my lens of exam						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and matner stated.		29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
	->-0) []	\bigvee		DE	30339		18/200	FC
	6		30. Name and address of person who com	pleted cause of death (I	tem 23a) (Type,	Print) d Cv	not Dd	Sul 3	1 Parti	UMP UDOBA
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sig	gnature	alle d	, , , , , , , ,	- 1000	· my	MUIL MUY DILLO

			For	State o	f Marylar				d Mental Hy	/giene		
			State Registrar			Cei	rtificate o	f Death		Reg. No. 2	007	00222
	Physicia	an	Decedent's Name (First, Middle, Las Marie Gross	t)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	ai	4a. Facility Name (If not institution, give	etraat and nu	mharl		4h City Town	, or Location of De			5. 200 unty of Deatl	The state of the s
5	Examin	er	Saint Joseph			nter	4b. City, Town		wson	40.000		timore
<u> </u>	Funeral		5. Social Security Number 6. Se			. last birthday)	if Under 1 Yes	r If Under 24 H	Irs. 8. Date of Bi	rth	9. Birth	hplace (State or Foreign
	Director		210 01 0211	□M 2 X F		87 Yrs.	Months Day	s Hours M	08/10	/1919	Col	VA VA
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	Aaryla f sho ed at	ō	MD			**	Baltim	ore				1 XYes 2 No
	the N	rect	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cor	untry?
	h with	Funeral Director	2537 Lauretta Avenue	2				21223		US/	A	
	ems 2	iner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	J.S. 13.	Was Decedent o	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yes or Numerto Rican, etc.)	0- 14.	Race - Amer Black, White	
2	or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes if Yes, Gi	24 No ve		1□Yes 2 <mark>X</mark> N		,	i		can American
Ś	hours turel" al Exe		15. Decedent's Ed	Year or D	ates:	16a Dece	dent's Usual Occ	unation		16h Kind (of Business/I	Industry
2	in 72 n "na Aedic	plet	(Specify only highest grad	de completed) College (1.405.5.	(Give	kind of work dor DO NOT use reti	ne during most of v red)	working	100170110	,	dubily
7	d with giene er tha	Completed	8th	College (1-401 5+)		nutrit	ionist		Univ. o	of MD -	College Park
2	al Hy d othe	Be (17. Father's Name (First, Middle, Last)					18. Mother's N	Name (First, Middle		na <i>me)</i>	
y	Ment Ment arked arked	2	William Da			T				Davis		
Ma	ges 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mentall Hygiene. At them 27 is marked other than "naturel" or items 23a or 28a-f show of items 21s marked other than "naturel" or other traumatic event, the Medical Exeminer must be notified at		19a. Informant's Name/Relationship (7 Serethia Gross/ Date						Baltimore,			
ני כ	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	State 20b.	Place of Dispo cemetery, crea	sition (Name of matory or other p	lace)	Date	20c. Locati	ion - City or	Town, State
	Pag tment tant: I		4 Donation 5 Other (Specify)	Bal		ational C		1/11/2007		ore, Mai	,
Dal	permit. Pages 1 and 3 Department of Health Important: if item 27 eny Injury or other tra once.		21. Signature of Funeral Service Licen	tones		22	2. Name and Add		Wylie Fu treet; Balt			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that one cause on e	caused the dea	ith. Do not ent	er the mode of d	ying, such as card	diac or respiratory	arrest,		Approximate Interval Between
a.	Physician		Immediate Cause (Final disease or condition	. SEP								Onset and Death
	/Medical Examiner		resulting in death)	d.	(or as a conse	quence of):						
	Lxammer	_	Sequentially list conditions,	b. — Due to	(or as a conse	guence of).						
	nsi 🔊 de	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duc to	(01 40 4 001130	qu onoo oi).						
,	n and ial-tra	Еха	resulting in death) Last	Due to	(or as a conse	quence of):						
500	icate be executed physician and streets the burial-transit	dical	•	d								
0	ng ph		IF FEMALE:									
200	leath certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome pf pregr birth 2 ☐ Fet	tal death 3	Ectopic pregna			23d.	. Date of deli Month	ivery Day Year
5	The law requires that the death certificate be executed are has been signed by the attending physician and are second to see as the burial-transit.	Physician/Me	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4∐Preg 9□Unkn	nant at time of lown	death 5L	Other (specify)					,
֭֭֭֭֭֡֡֟֝	that the detack		Part II. Other significant conditions	ontributing to d	eath but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
OI CI,	quires n sign ald be	d by							_ 10	Yes 2	lo 3 🗆 Pro	obably 4 □Unknown
5	s bee	Completed							24a. Was	s an 2	4b. Were au	utopsy findings available completion of cause of
_	The la	mo							— auto perf 1□ Yes	opsy formed? 2¶0 No	pnor to death?	
2	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						Death (Check only			<u> </u>
> 5	Physician: r this certificaral director,	To	1 ☐ Yes 250 No			ER/Outpatier	" 3 DOA		g Home 5 ☐ Res			cify)
5	ding F h. After funera	Certification:	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigation		of injury ith, Day Year)	28b. Time o Injury		jury at /ork? □ Yes 2 □ No	28d. Describe	how injury o	curred	
	Atten r deal ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	e of injury - At h	nome, farm, sti	eet, factory, offic	e	28f. Location	(Street and Nown, State)	umber or Ru	ıral Route Number,
5	tal or is after al Dir	Cert	4 LI TOTALOGO	Dunc	ing, etc. (Spec				City of 10	wii, State)		
	To the Hospital or Attending Physician: The law requires that the do within a hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	niner: On the b					lace, and due to the occurred at the time			
	To th within To th comp	Ň	29b. Signature and title of certifier	000	\cap		29c. Lice	nse number		29d. Date si	gned (Monti	h, Day, Year)
	T		· Colons	rry			D25	5886		Jan	, 5	-200 t
	10		30. Name and address of person who	completed cad								•
	Sta	to	LILIA CEBALLOS 31. Date filed (Month, Day, Year)	32 1				TOWSON	, MARYL	AND 2	1204	
	Registr		1120 A Q 2007	Re.	was d	1 dec	de					
			THE WITH WE SELLIN	N. A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Marie Jan	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle,, Last) 2. Date of Death 3. Time of Death HAX Th 200 Day Month Physician Evelyn 30 DM Janua /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 ☐ M 2 🛛 F 83 August 23, 1923 MaryTand 218-12-2577 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 Mainfield Avenue 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □ Yes 2 No White Specify: Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic Engineer At Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William King Ursella Dohler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Walther Avenue-Baltimore, Maryland 21214 Michele Hax-daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Evans, Funeral vale Jan. 9,2007 1 ☐ Burial 2 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) & Cremation -Bel Air 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility
PEACEFUL ALTERNATIVES 2325 York Road Timonium, MD 21093 AND FUNERAL & CREMATION CENTER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ers thou disease or condition resulting in death) /Medical Due to (or as a consequence of); Gue week Examiner 4 Sequentially list conditions, if any, leading to introducts cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Line to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XINo certificate 1 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

31. Date filed (Month, Day, Year)

doch

certifier

29b. Signature and title of

32. Registrar's Signature

30. Name and address of person who completed cause of death stem 23a) (Type, Print) Balti mucle.

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mary	land / Dep		Health and	Mental Hy	giene 007 00224
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Suzanne T. Held A. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea	2. Date of Dea Month January	ath Day Year 3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 216–50–0357		yrs. last birthday) Yrs.		ore City	S. 8. Date of Birt	N/A
the Maryland	28a-f show	Director	Usual Residence of Decedent		. City, Town or Lo				10d. Inside City Limits 1 ☐∰es 2 ☐ No
5-0036 72 hours after death with the Maryland	Department of health and Mental Hygiene. Uppartment of health and Mental Hygiene. But injury or other traumatic event, the Medical Examinar transfer colities at once.	by Funeral	509 Charing Cross	Road 2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		21229			Inited States 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ad within 72 hours af	ygiene. Ior than "natu I, II e Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wo	orking	16b. Kind of Business/Industry Education
Maryland	and Mental Hy s marked oth iumatic eveni	To Be	17. Father's Name (First, Middle, Last) Travers Held 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	Mabel W		Maiden Sumame) r, City or Town, State, Zip Code)
Baltimore, M	ant of Health a		Jeanette McDonald 20a. Method of Disposition 1 Burial 2 Stremation 3 Re 4 Donation 5 Other (Specify)	moval from State	b. Place of Dispo cemetery, crem	Charing C sition (Name of natory or other plai	ross Road	d Baltimo	ore, Maryland 21229 20c. Location - City or Town, State
Baltir Permit. P	Importan any injur		21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complice shock or heart failure. List only one	Ther	Da 53		ss of Facility Seber Fund Son Ave	eral Home nue Balti	unore. Maryland 21229
760, tie be executed E	hysician dedical the burial-transit	ilcal Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a con Due to (or as a con Due to (or as a con	sequence of): +eses sequence of):	Cer	g, soon as cardar	or respiratory and	est, Approximate Interval Between Onset and Death
.O. Box 68 the death certifica	by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 0 9 Unknown	c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delivery Month Day Year
Records, P.O he law requires that the	een signe	Completed by PI	Part II. Other significant conditions control ALCOHOL'S		resulting in the un	derlying cause giv	en in Part I.	1 □ Ye	
of Vital Re	± 5		25. Was case referred to medical examiner?	spital:		Otho		autops perform 1 Yes 2	yed? death? 1 Yes 2 No
C Buil	sctor: After this by the funeral d	H 1	1 Yes 2 No 27. Man of Death 1 atural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year	t home, farm, stre	28c. Injun Work	4 □ Nursing H	28d. Describe ho	reet and Number or Rural Route Number.
Hospital or 24 hours after	To the Funeral Dir completely filled in	edical Cert	29a. Certifier 1 Certifying Physic	building, etc. (Specian: To the best of my rr: On the basis of exame and manner stated.	cnowledge death	occurred at the time stigation, in my op	ne, date and place, pinion, death occur	City or Town	. State) use(s) and manner as stated. Ite and place, and due to the cause(s)
To the	To th	X	29b. Signature and title of certifier	surer	Ų.	29c. License	o number	29	d. Date signed (Month, Day, Year)
7	Stat Registra	e	30. Name and address of person who comes	324 Applistrar's Sig	MA	MD.	POBO	x 452	Timonium 21094

Replacenunt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Amend #29d, I	State of M perDVR, g863,	arylan 1/25/	d / Depa 07 TF _o ,	artment of F	lealth a	nd Men		0	(\rangle = 1)	00005
			1. Decedent's Name (First, Middle, L			- Cei	incate or i	Dealli	2. [Re Date of Death	g. No. //	W-	3. Time of Death
	Physicia			Happel, Jr					Ja	Month nuary	Day 4	2007	11:30 🖔
	/Medic		4a. Facility Name (If not institution, ga		•		4b. City, Town, or	r Location of		<i>y</i>	4c. Coun	ty of Death	11.50 р
			3 Moss View Cour	t			Catonsv				Balt:	imore	
	Funeral	d.		Sex 7. Ag 1 → M 2 □ F		last birthday)	If Under 1 Year Months Days	If Under 2- Hours	Min. (Date of Birth Month, Day,	Year)	9. Birthpl Coun	lace (State or Foreign try)
×	Director		219-18-6470 Usual Residence of Decedent	- X 2	80	Yrs.			Ja	nuary	1 1927	Mar	yland
	and t		10a. State 10b. County		10c. City	y, Town or Lo	cation					11	0d. Inside City Limits
	Mary -f sho fled a	ţo	MD Baltimo	re	Cat	onsvil	16						1 □Yes 2 No
	with the Maryland a or 28a-f show the notlified at	Director	10e. Street and Number		Joan	.0110 (13	10f. Zip Code			10	g. Citizen o	f What Coun	try?
	th with		3 Moss View Cou	rt			21228				U	SA.	
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	•	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify , Puerto Rica	Yes or No- n, etc.)		ace - America	
36	s afte ; or it amin	by Ft	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give			1 □ Yes 2 ☑ No	Specify:			Spec		
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show kdical Examiner must be notifiled at	pe pe	15. Decedent's	Year or Dates:	MMTT	16a Decer	dent's Usual Occup	ation		- 11	6h Kind of	Business/Ind	
5	in 72 n "na Nedic	Completed	(Specify only highest g	rade completed)	F. \	(Give	kind of work done of NOT use retired	during most	of working	1	0011111001		,
212	d within giene.	E	Elementary/Secondary (0-12)	College (1-4or 5+	0+)	Vice H	President			į	Real	Estate	
	hould be filed within 72 houd Mental Hygiene. marked other than "natu matic event, the Medical	BeC	17. Father's Name (First, Middle, Las	st)				18. Mother	r's Name (Fir	st, Middle, M	laiden Surna	ame)	
<u>la</u>		2	Joseph G. Ha	ppel, Sr.		·		Catl	herine	Hed	rick_		
Maryland	2 s ar		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number	r or Rural Ro	ute Number,	City or Tow	n, State, Zip	Code)
	s 1 and of Health item 27 other tr		Anita W. Happel 20a. Method of Disposition	- wife	20h B		SS View C	ourt,	Caton Date			21228	
Š			1 🔀 Burial 2 ☐ Cremation 3		C	emetery, crer	natory or other plac	i				,	, –
altimore,	그는 꾸 등	3	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	08800			Cemetery		1/8/20		larks	ville,	MD
Ba	permi Depar Impor any ir		I Secre CO		acNat	ob Ma 30	Name and Address CNabb Fu 01 Freder	neral' ick Ro	Home, oad, C	P.A. atonsv	ille,	MD 2	1228
п			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each l	d the death ne.	h. Do not eut		(3)			~ ~		Approximate Interval Between Onset and Death
V.	Physician		Immediate Cause (Final disease or condition resulting in death)	a		re	aler	x g	nei	ems	ren	10	veek
	/Medical Examiner		resulting in deathy	Due to (or as	а сопѕед	uence of):		1					
		ē	Sequentially list conditions,	b. Eus to (or as	z consect	uence of):							
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	exec an an		resulting in death) Last	Due to (or as	a consequ	uence of):							
68760,	icate be executed physician and s the burial-transit	dical		d									
_		Med	IF FEMALE:										
Вох	death certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3□	Ectopic pregnancy	/				Date of delive Month	ry Day Year
0	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time or a	eath 5L	Other (specify)						·
Δ.	that the de ned by the a		Part II. Other significant conditions	contributing to death t	out not resi	ulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	acco use co	ntribute to th	ne cause of death?
rds,	quires n sign lld be	d by								1 ☐ Ye	s 2 No	3 ☐ Prob	ably 4 □Unknown
Record	aw require s been sig should b	Completed								24a. Was an		o. Were autor	psy findings available
Re	The far ate has page 2	mo								autopsy perform 1□ Yes 2	red2	death?	npletion of cause of 2 □ No
Vital		Bec	25. Was case referred to medical examiner?					26. Place		eck only one			
or V	Physician: this certific ral director,	P P	1 ☐ Yes 2 ☐ No			ER/Outpatier		4 ∐ Nur		5 Resider			1)
	ding P. .r. After I	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inji (Month, Da	iry ly Year)	28b. Time of Injury	Wor			Describe how	w injury occu	urred	
Division	or Attendater death Director:	icat	2 Accident investigati 3 Suicide 6 Could not	h a	iury - At ho	me farm str		Yes 2 □ N		ocation (Str	eet and Nun	nher or Rura	l Route Number,
Dίν	after after i Direct d in by	Certification:	4 Homicide determine	building, e	tc. (Specif	y)	eet, factory, office			City or Town,		noci oi ribia	Tribute Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 ☐ Certifying I (Check only one) 1 ☐ Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examina	wledge, death	h occurred at the tir vestigation, in my o	me, date and opinion, deat	d place, and the occurred a	due to the ca t the time, da	use(s) and rate and place	manner as st e, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1.			29c. Licens	e number		29	d. Date sign	ned (Month, i	Day, Year) 2007
			10/1/ Hoth	y rul	7	mo	00	500	2(MU	myo	21 200 g
			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	N. Ch	ales	St	Ba	Ho.	Md	2(20)
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	1						
	Registr	ar	JAN 2 5	2007	2000	13. A	bell						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrer	State of Maryl		artment of H			ene 007	00226
	Physici	an	Decedent's Name (First, Middle, La					Date of Death Month	Day Year	3. Time of Death
	/Medio	al	DONALD 4a. Facility Name (If not institution, gru	GRIFFITH	H	UGHES	Location of Death	JANUARY	3, 2007 4c. County of Death	5:10 P.M
ч	Examir	er	7709 PARK DRIVE	e street and numbery			VILLE		BALTIM	ODE
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	ff Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		place (State or Foreign
	Director		218-01-0662	1XM 2□F 86	Yrs.	World's Days	Hours Will.	8. Date of Birth Month, Day, Y 4/25/1920	MĂR)	LAND
	and we		Usuaf Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I eh	to	MD BALTI	MORE	PAF	RKVILLE				1 ☐ Yes 🎾 No
	or 28s	lrec	10e. Street and Number			10f. Zip Code	- 1	100	g. Citizen of What Coul	ntry?
	ath wi	rai	7709 PARK DRIVE			212	34		USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or iteme 23s or 28s-f show other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2ሺ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
5-0	72 hc	etec	15. Decedent's E (Specify only highest gr.	ducation ade completed)	(Give	dent's Usual Occupa	furing most of work	ring 16	b. Kind of Business/In	dustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired WITCHMAN)		RAILROAD	
	e filed within al Hygiene. I other then " vent, the Me		12TH GRADE 17. Father's Name (First, Middle, Last)		WII OIN MEN	18. Mother's Name	e (First, Middle, Ma	uden Sumame)	
<u>'lan</u>	should be and Mental smarked o urnatic eve	To Be	ELLIS GRIFFITH 1	HUGHES			GLADYS	MARIE BA	ALDWIN	
Maryland	2 sholl and h		19a. Informant's Name/Relationship (-			City or Town, State, Zip	Code)
	1 and 1 Health tem 27		ROBERT HUGHES/SOI 20a. Method of Disposition		1410° b. Place of Dispo	1 SCOFIELI			STONE, MD	21530
Baltimore,	permit. Pages ' Department of H Important: If its any injury or ot		1 ⅓ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	Removal from State (y)	PARKWOOD	CEMETERY	1/8/	'2007 I	BALTIMORE,	MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lice	Hay	8	521 LOCH	RAVEN BLV	VD. TOWS		OME, F.A. 1286
<i>J.</i>	Physician /Medical Examiner		23a. Part P. Enter the disease, or come hock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	estert	er the mode of dying	g, such as cardiac		i.	Approximate Interval Between Onset and Death
75	1.7	niner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of):			_		
8760,	ate be executed hysicien and the burial-transit	ai Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
9	uficate ig phy as the	edic	-	d						
P.O. Box	law requires that the death certific; as been signed by the attending ph 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of defive Month	ery Day Year
	w requires that been signed b should be dete	ρ	Part ff. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	CCO use contribute to the	ne cause of death?
Division of Vital Records,	The ate h	Completed						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No
Z.	sician: Th certificate irector, pag) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe		h (Check only one)		
o	y Phys er this eral di	n: To	1 Yes 20 No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of	IL 3 DOA	4 Nursing Ho	28d. Describe how	infury occurred	y)
ion	Attending Physician: ir death. ector: After this certificator. by the funeral director.	atio	UNaturaf 5 ☐ Pending 2 ☐ Accident investigatio		r) Injury		res 2 No			
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not b	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
	he Hospital or n 24 hours afte he Funerel Dir pletely filled in i	edical	29a. Certifier (Check only one)	nysicien: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the caus red at the time, date	se(s) and manner as so and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1		29c. License	150171-	29d	ate signed (Month,	Day, Year)
_	4x,		30. Name and address of person who	pleted cause of death (Item-23a) (Type,	Print) L Hert	in ai	d Bel	t- MD 2	1234.
	Sta Registr	200	31. Date filed (Month, Day, Year)	32 Registrar's Si		WAD TO				
DH	MH 17 Rev 1/2		JAN 0 9 2	007 Begins	RI FAM					

ORIGINAL

		1 - For State Registrar	State of I	Marylan				ealth a	ind M	F	Reg. No.	2007	002	27
Physici /Media		1. Decedent's Name (First, Middle, Kathleen	Ann		н	awkir	าร			2. Date of Dea Month	Day	Year Zoc		M
Examir		4a. Facility Name (If not institution,	_	er)				Location of	f Death			County of De		
		8181 Great Bend		A a a //a	last birthday)		Bur	nie # Under 2	24 Hrs	0 D-1 - 4 D-1		ine Ari		
Funeral Director		290-48-1384	1 M 2 M F	57	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day Jan. 21	Year)	949 To	inthplace (State or Pountry) ledo, OH]	LO LO
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City	Limits
Maryl	ţ	MD Anne	Arunde1	Gle	n Bunr	ie							1 □ Yes 2	No 🔀
r 28a	rec	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zi	p Code				10g. Citiz	zen of What C	Country?	
th wit	aiD	8181 Great Bend	Road			2	1061				U.	S.A.		
ING 21215-UU36 be filed within 72 hours efter death with the Maryland lat Hygiene. d other than "netural", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force ed 1 Yes 2 If Yes, Give Year or Date	is? ∑No		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, lite, etc. White	
27215-0036 d within 72 hours eff glene. or than "netural", or the Wedgel Exami	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 1 2	s Education grade completed) College (1-4c	or 5+)	life.	kind of wo DO NOT L	ork done o	lurina most	of worki	ng		nd of Busines	s/Industry ministrat	-1
N pos		17. Father's Name (First, Middle, L	ast)		Secre	cary	T	18. Mother	r's Name	(First, Middle,			ministrat	LIOII
	To Be	Paul J. Gillen	•							d Nykod				
ire, Maryland s 1 and 2 should be file if Health and Mental Hy Item 27 is marked oth other treumatic event	۱	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Addres	s (Street a			al Route Numbe	-	Town, State,	Zip Code)	
C = F		Robert Hawkins	/ spouse						ad (Glen Bu	rnie	, MD 2	1061	
or the first of th		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation	3. □Removal from Sta	20b. F	Place of Dispo emetery, crer	sition (Na natory or	me of other plac	e)	Jan.	11.	20c. Lo	cation - City o	or Town, State	
Pages Pages ment of ant: If It ury or o		4 Bonation 5 Other (Sp		St	. Mary			У	200	07		nton,		
Baltimore, permit. Pages 1 a Depertment of Hee Important: If Item any Injury or othe		21. Signature of Funeral Service L	igendee //	mois						gleton I Glen Bu			me, P.A. 21061	
Physician /Medical		23a. Part 1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aMy	o line.	rd-s/			_		or respiratory ari	rest,		Approximate Interval Betwee Onset and De	
Examiner	er	Sequentially list conditions if any, leading to immediate		as a consequence of the second	uence of):	A							425-	5
and transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		BNS1								415-	-
8760, Caste be executed by sicien and the burial-transit	icai	Tooling in county 2001	مغدد	as a conseq	D									
T.O. BOX 68 If the deeth certifical by the attending phy teched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta tat time of d	Ideath 3□]Ectopic p] Other (s			43-45		2	3d. Date of do Month	elivery Day Ye	ar
- 2 BB	δ	Part II. Other significant condition Happe Thy soco				nderlying	cause give	en in Part I.	_	23e. Did to			to the cause of dea	
COLD w requir been si	etec	Hypery mi	1 Resil	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dave		1900	600		-				
	Completed	25. Was case referred to medical									sy med? 242 No	24b. Were a prior to death?		ailable ise of
	o Be	examiner?	Hospital:	atient 2 🗆	ER/Outpatien	t 3□Di	Othe		rsing Hor	ne 50 Besid		☐Other (Sp	acifu)	-
		27. Manner of Death	28a. Date of li (Month, i		28b. Time of Injury		28c. Injury Work	at	- 1	28d. Describe h			o cny)	
DIVISION I or Attending after death. I Director: After d in by the funer	Certification	2 Accident investigation 3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At he etc. (Specify	ome, farm, str			100 201		281. Location (S City or Tow	itreet and n, State)	i Number or F	Rural Route Numbe	er,
To the Hospital within 24 hours a To the Funerel (completely filled	edicai C	29a. Certifier 15 Certifyin (Check only one) 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examina	wledge, death tion and/or in	vestigation	at the tim	ne, date and pinion, deat	h occurre	and due to the o	aus (s) date and	and manners place, and du	es stated. se to the cause(s)	
To the within 2 To the complet	M	29b. Signature and title of certifier	In.	MS)	29	c. License	number	51		29d. Date	signed (Mor	O Z	
6) v		30. Name and address of person w)2 Pa	saden	a MI	21122			P-	
Sta Registi		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ture	de)								

State of Maryland / Department of Health and Mental Hygiene?

00228

				Certificate of Death	Reg. No.	007	00220
			1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey	Year	3. Time of Death
a.	Physicia /Medic	_	Mary Elizabeth Handy		January 6, 2		4:30 PM
	Examin	_	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo	cation of Deeth 4c. Co	unty of Deeth	
			Iorien Assisted Living & Skilled N 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birth		9 Date of Righ	ford	place /State or Formige
П	Funeral Director		1□M 2□xF v	Months Days Hours Min.	(Month, Dey, Yeer)		place (Stete or Foreign ntry)
Ø.		ŀ	219-34-6703		July 22, 193	/ Mary	Tano
	yland		10a. Stete 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Se-1's	cto	Maryland Harford Edgewo	od			. 1 □ Yes 2 □ No
	₹ 2 ¥	Director	10e. Street end Number	10f. Zip Code	10g. Citizer	of Whet Cou	ntry?
	ath w	la	3905 Love Avenue	21040	USA	Race - Ameri	one ledine
	ar de	Funeral	11. Mentel Stetus 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of Hispenic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 		Black, White,	
20	rs aft	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Sp	ecify:	hite
Ş	d 2 should be filed within 72 hours aftar death with the Maryland and Mantal Hygiena. 7 is merked other than "natural", or items 23a or 28a-f show traumstic event, the Modical Examinar must be notified at		15. Decedent's Education 16a. I	Decedent's Usual Occupation	16b. Kind	of Business/in	
Maryland 21215-0020	F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	(Give kind of work done during most of worki life. DO NOT use retired)	ng		
21	ified wit Hygiene other the ent, the	E		emaker	Own		
2	a de financia de f	Be	17. Father's Neme (First, Middle, Last)		(First, Middle, Maiden Su	meme)	
<u>Xa</u>	should be and Mantal americal over	ို	Walter Earl Bond		Mae Carter		
ā	12 should be filed what and Mantal Hygie Is marked other traumatic event, the		, , , , ,	Meiling Address (Street and Number or Rure		wn, State, Zij	o Code)
	1 and Health Im 27 ther tr	-	Bill Handy / Husband P. (20a. Method of Disposition 20b. Place of 0	O. Box 813, Edgewood Disposition (Name of	MD 21040 Date 20c. Locat	ion - City or T	own. State
Baltimore,	Pages 1 and nant of Healt int: If Item 27 iry or other i		1X Burial 2 ☐ Cremetion 3 ☐ Removal from State	, cremetory or other place)		•	
H	it. Partural ritarit		4 □ Donetion 5 □ Other (Specify) Bel Ai: 21'Signature of Funeral Seprios Licensee	r Memorial Gardens 1		ir, Ma	ryland
Ba	permit. Pag Departmant Important: t any injury o		21. Solitation of Pullet a Say Vol.	22. Name and Address of Fecility McComas Funeral Hor			
			Africa II Province Chus	1317 Cokesbury Road		Maryla	nd 21009 Approximate
1			23a. Part1. Enter the disease or complications that caused the death. Do no shock, or head feilure. List only one cause on each line.	A enter the mode of dying, such as cardiac o	respiratory arrest,		Interval Between Onset and Death
april 1	Physician /Medical		Immediate Cause (Final	1.11 6 - 1 - 0			
18K	Examiner		disease or condition resulting in deeth) Due to (or as e or	CUNG CANCER		1	
	4	Jer	Due to (or as a co	risequence oi).		1	
3.	ficata be executed physician and ts the burial-transit	Examiner	Sequentially list conditions Due to (or as e co	onsequence of):		1	
0	e exection are lared are are lared are are lared are lar	EX	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as e co			i	
68760,	ata b hysic the br	edical	that initieted events resulting in death) Last	insequence of):			
9	laath certifics attending pl d for use as t	Ž					
Box	ath co	lan					
o	law requires that the daath certificata be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit	Completed by Physician	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pert I.			o the cause of death?
<u>a.</u>	that the ed by detac	Æ	BRAIN METS, SEIZURE DIS	ORDER	1 □ Yes 2 □ 1	No 3□ Pro	bably 4 Unknown
Vital Records,	uires sign ld be	d b	BRAIN METS, SEIZURE DIS CEREBROVASCULAR ACCIDENT,	,	24a. Was en eutopsy		ere autopsy findings
Ö	w require been sig should t	lete	CEREBROVASCULAR ACCIDENT,	DYSCIPIDEMIA	performed?	CC	vailable prior to ompletion of cause death?
Ř	The law ate has paga 2	dmo			1□Yes 2Æ1		□Yes 2□ No
Ē		B B	25. Was case referred to medical	26. Place of Death	(Check only one)		
	Attending Physician: ordeath. ector: After this certific by the funeral director.	Lo B	examiner? 1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outp	Other	me 5□ Residence 6□	Other (Speci	fy)
0	g Ph erthi		27. Manner of Deeth 28b. Til (Month, Dey Year) 28b. Til (Month, Dey Year)		28d. Describe how injury o		
<u>S</u>	ath. oath. or: Aft	atio	2 Accident investigation	M 1 Yes 2 No			
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	 Location (Street end N City or Town, Stete) 	lumber or Rur	al Route Number,
	Ital o						
	Hospital or 24 hours afte Funeral Dir stely filled in	edical	29a. Certifier (Check only one) 1				
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Me	29b. Signeture and title of certifier	29c. License number	29d. Date s	igned (Month,	Day, Yeer)
	⊢ ≱ ∺ ŏ		Millows Mx	NICTIM	1101	1007	
	1.	ŀ	30. Name end eddress of person who completed cause of deeth (Item 23e) (T	D45349 Type, Print)	1/6/2		
	4		SURESH DHANTANIMA, 6225.	UNION AVE HAVRE	DE GRACE	MDZI	078
	Sta	te	31. Date filed (Month, Day, Year) 32 pegistrar's Signature	1 4.	7		
	Registra	ar	EASI O 9 2007 Brown &	DOME !			

			1- State of Maryland / Department Certificat	nt of Health and Me te of Death		2007	00229
		2	1. Decedent's Name (First, Middle, Last)		Reg.	No. UUI	3. Time of Death
4	Physic /Medi			<u>ד</u>	Month	Day Year	
	Exami			Town, or Location of Death		4c. County of Dea	
-			5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) if Under	r 1 Year If Under 24 Hrs. 8		Boite	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 920-14-2664 17 M 2 F 82 Yrs.	Days Hours Min.	Date of Birth (Month, Day, Ye. /08/1924	ar) 9. Bir	thplace (State or Foreign ountry)
disc	D		Usual Residence of Decedent	1/2/	/00/1924		NY
	show	2	10a. State 10b. County 10c. City, Town or Location BALTIMORE OWINGS	MILLS			10d. Inside City Limits
	the M	Director	2 10e. Street and Number				1 ☐ Yes 2 X No
	3a or			1117	10g.	Citizen of What Co	•
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	dent of Hispanic Origin? (Specif cify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	A 3 Widowed 4 □ Divorced If Thes, Give WW II 1 □ Yes		čan, etc.)	Black, Whit	WHITE
5-003	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo.	al Occupation	16b.	. Kind of Business/	/Industry
7	within 72 ene. than "nai he Medici	mple	Elementary/Secondary (0-12) College (1-4or 5+)	,			
2	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	ALES 18 Marked No. 15		PLIANCE	
Maryland 2121		To Be	1ACOD	18. Mother's Name (F ESTHER	тгят, іміааіе, імаіа		DELMAN
ary	d 2 should th and Men 7 is marke traumatic			(Street and Number or Rural R	Route Number, City	y or Town, State, 2	Zip Code)
_	s 1 and 3 lift Health item 27 other tra		FRITZIE SCHWEITZER / SISTER 10811 BARC	ONET ROAD - OWI	NGS MILL	.S, MD 21	.117
nor	e = 1		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ne of Date (ther place) MEN 01/07/		ODLAWN,	
altimore,	permit. Pag Department Important: any Injury once.		((posiny)			V & BROS.	
מ	20 5 6 0		Such III auth 8900 F	REISTERSTOWN RC)AD - PIK	ESVILLE,	MD 21208
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):				Onsor and Dead
	Examiner						
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c				
,	cate be executed ohysician and the burial-transit	xan	that initiated events resulting in death) Last				
00/	ysicial	dical	d.				
00	ntifica ng ph	Medi	I E EEMALE.				
S	ath ce ttendi or use	ian/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre	egnancy		23d. Date of deli-	•
	ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (special contents) of the special contents of	ecify)		Month	Day Year
Ľ	s that ned b e deta	by Pr		use given in Part !.	23e. Did tobacco	use contribute to	the cause of death?
SOLOS,	equire en sig ould b	ed b	Croha's Disecte		1 Tes	2☑No 3☐Pro	bably 4 🗆 Unknown
֝֝֝֟֝֝֝֝֝֟֝֝֝֝֝֟	law r las be	Completed			24a. Was an	24b. Were aut	topsy findings available
	cate h	Con			autopsy performed? 1 Yes 2 N	death?	ompletion of cause of
=	slclan certifi rector	Be		26. Place of Death (Ch			
5	Phys er this eral dii	유	1 Inpatient 2 EH/Outpatient 3 DO/				ify)
2	ath. r: Afte e fune	atior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	Describe how inju	ary occurred	
2	or After ter de ilrecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homlcide 3 ☐ Suicide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 4 ☐ Homlcide 5 ☐ Could not be determined building, etc. (Specify)	=0	Location (Street a City or Town, Stat	and Number or Rur	ral Route Number,
ָ	spital of ours at ours at lilled i					,	
:	or the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred a	due to the cause(s at the time, date ar	 and manner as s d place, and due 	stated. to the cause(s)
1	With To t	Σ	29b. Signature and title of certifier 29c.	License number	29d. Da	ate signed (Month,	Day, Year)
	0,1	-	20 Name and address from	029085	Joh	wery 4	2007
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	Stat	٠	31. Date filed (Month, Day, Year) 32. Registrar's Signature	in court a	000		21133
H	Registra	- 1	31. Date filed (Month, Day, Year) 32. Begistrar's Signature				_
МАН	H 17 Rev 1/200	11	39.010				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #1, perMD, State of Manyland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) Thomas H. Hughes, 2. Date of Death 3. Time of Death Year Month **Physician** Jan 1:50 PM 2007 /Medical Name (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria HOSOITAL If Under 24 Hrs. 8. Social Security Number **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□F Days Min Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 No 2 No Completed by Funeral Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Rak estingh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be h and Mental H nomas HughesS 2 19a. Informant's Name/Relati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 of Disposition (Name of 20a. Method of Disposition Date 20c. Loca Depertment of H important: If its eny injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (ar 21. Signature of Funeral Service que 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner of the liver Circhosis f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ed by the ettending physicien and deteched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Alcoholism resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rthis certificete hes been signe ral director, page 2 should be 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes Director: After this certification by the funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: Certification: To 1 Yes 2 No 1 Thpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 29a. Certifier Check unity 2 Medical E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinier. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MD AT2438946 January 4, 2007 30. Name and address of person who compound cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

etta J. Wright

JAN 09

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

Union Memorial

HOSD, tal

07-00113

harles J Hajek		State - For State egistrar	of Maryland / I		nent of He cate of De		a ivienta	al Hygi	ene Reg	. No. 200	17 00031
Physician	1	. Decedent's Name (First, Middle,Las	st)					l N	Date of Death Month	2007	3 Time of Death
Medical Examin	er	Charles J. Ia. Facility Name (if not institution, given	Hajek		T _{4b} C	ity, Town, or	I ocation of		anuary 4,	4c. County of De	
		Franklin Square Hospital	e street and namber)			osedale				Baltimore C	1
Funeral Director	5	Social Security Number 6 S		In yrs. last b		Under 1 Year	_	Min.	Date of Birth	Fo	Birthplace (State or reign Maryland Country)
	ι	219–18–9462 1 L Jsual Residence of Decedent							12/1/1	721	
w any	- [Oa. State 10b. County	10	Oc City, Tow	n or Location						10d. Inside City Limits 1 Yes 2X No
Maryland 28a-f show any d at once.	٩	Maryland Baltimo:	re	<u>Middle</u>	e River	f. Zip Code			100	Citizen of What C	
th the Maryland 23a or 28a-f sho notified at once	Director					21220			T	. S. A.	
with th	<u>_</u>	13015 Eastern Av	12. Was Decedent Ev	er in U.S.	13. Was De	cedent of His			y Yes or No-	14. Race - An	nerican Indian, Black,
death wi	Funeral	1 Never Married 2 XMarried	1 X Yes 2	No		specify Cubar		Риело Кіс	an, etc.)	White, etc	
s after iral",	≥⊢	Widowed 4 Divorced Divorced Specify of the second of the se	of Dates: 943	-1945	1 Yes	s 2 X No		ind of work	done	Specify: What is a specify: What is a specify: What is a specific with the specific	
5-0036 He within 72 hours after Hygiene dother than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+		during most of						,
036 ithin 7 re r than 1edica	ď	12	_		Lathe M	achini				Steel	
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f shu ic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last		_				· ·		aiden Surname)	
2 9 8 E 2	10 Be	Joseph Hajek 19a. Informant's Name/Relationship (9b. Mailing Ad	dress (Stree	Mar et and Numb		Marek I Route Numb	per, City or Town, S	tate, Zip Code)
O ₹ 5 ₹ 1 .	-	Anna Marie Chris	t (Daughter)	12401	Dover	Road	Reis	tersto	wn, Mary	land 21136
ore, MC ss 1 and 2 s of Health ar If item 27		20a Method of Disposition 1 X Burial 2 Cremation 3		20b Plac	e of Disposition atory or other p		metery,	1/	ate 'O	20c. Location - City	y or Town, State
imor Pages ment of lant: If		4 Donation 5 Other Specify	/		Holy R	edeeme	r Cem	. 20	007		e, Maryland
Baltimore, permit Pages I an Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Lice	nsee		Bruz	dzinsk	s of Facility I Fun	eral	Home F	PA	mr.l 21221
Physician	_	23a. Part I. Enter the disease, or com		e death. Do	not enter the m	node of dying,	such as ca	rdiac or re	spiratory arre	st, shock, or heart	ryland 21221 Approximate Interval Between Onset and
/Medical		failure. List only one cause on a Immediate Cause (Final disease	Gastrointest	inal he	morrhage						Death Death
Xaiiiilei		or condition resulting in death)	Due to (or as a consequence Feeding tub		ment						
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq				_				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseq	uence of).							_
suted nd ransit		events resulting in death) Last	,					- 			
60, ate be executed hysician and e burial - transit	Physician/Medical	X UNPENDED	X AMENDED #23a- #2.	b, PII, perDVR	,27,28a-f , g863, 1	, perME. /9/07 T	, g864, T	2/6/0	7 TT		
3760, ficate be g physici s the buri	₩.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnan	су			pregnancy		23d. Date of deli Month	very Day Year
Box 6876. : death certificate the attending play ed for use as the 1	iciar	past 12 months?	4 Pregnant at to	me of death	- =	(Specify)		programoy			 ,
Bo he deat	Sh's	1 Yes 2 No 9 Unknow Part II. Other significant conditions	9 Ulkilowii	but not rocul	ting in the unde	vrlvina causa	aiven in Par	rt I	23e Did tot	pacco use contribut	e to the cause of death?
ires that the de signed by the	ক্র	Massive cerebral	_	but not resul	ang in the ande	mymg cadse	giverritta				Probably 4 Unknown
ds, require	eted								24a. Was a		e autopsy findings available to completion of cause of
e law te has b	Completed								autops perform	ned? deat	
al Remitted	ابه	25. Was case referred to medical				26.Plac	e of Death (Check only	<u> </u>		
of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	TO B	1 0 100	Hospital 1 Inpatien		//Outpatient 3	DOA	Other ₄	Nursing H			Other
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sa tier death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death 1 Natural 5 Pending	28a Date of Injury (Month, Day,Ye	ar)	b. Time of Injur		ury at Workî Yes 2 χ	No S	stomach v	ow injury occurred wall bleed	
Sion Attent	icati	2 X Accident Investiga	28e Place of Init		L:15 pm , farm, street, fa			1 1	eeding f. Location (S	tube placem treet and Number o	ent r Rural Route Number City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	Suicide 6 Could no determin		erating	g room			F	or Town St Cosedale	ate) 9000 Fr. , MD	r Rural Route Number City anklin Sq. Dr.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C		cian: To the best of my er: On the basis of exam and manner stated								
F 3 F 8	Me	29b. Signature and title of certified	/ // //			29c. Licen		-		29d. Date signed	
		YICA	TIV			0.0	.M.E.			January 5, 20	JU /
		30 Name and address of person who Susan Hogan MD. As:	o completed cause of de sistant Medical Ex			Street. Ba	ltimore. N	/ID 2120	1		
St	ate	31 Date filed (Month Day Veer)	32 Redistrar	- 0 1							
Regist	rar	JAN 0	ZUU!	William It	1 April	SER D					

		1	For State	State of Maryland		rtment of Health and tificate of Death		giene) (7 00232
		1	Registrar . Decedent's Name (First, Middle, Las	()			2. Date of Dea	ith 12	3. Time of Death
Phys			NIOCHUA 7	TOHNSON.			JANUAR		Year 8.15 P M
	dica ninei		a. Facility Name (If not institution, give			4b. City, Town, or Location of De		4c. County o	
			Northwest t	taspital		handall-	tour	Bal	timore
Funer	al	5	Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year If Under 24 H Months Days Hours M		, Year)	Birthplace (State or Foreign Country)
Directo	or		212 20:07/14	18	Yrs.		08.29	1428 1	Maryland
and * =		-	Usual Residence of Decedent Oa. State 10b. County	10c. City	, Town or Loc	ation			10d. Inside City Limits
Mary -f sh	3	3	MD Baltin	mara II	indeu	- MILL			1 ☐ Yes 2 📈 No
r 28a	1	1	0e. Street and Number	nue o	maca	10f. Zip Code		10g. Citizen of Wi	nat Country?
h witi	2	2	2812 Cunningha	m Drive		21244		USA	
eep .	Emerei Olrector	1	1. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. W	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
s atte	1	<u>.</u>	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1	☐ Yes 2 No Specify:		Specify:	D 1 1
hour turn	7	2	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a Deced	ent's Usual Occupation		16b. Kind of Bus	DIACH siness/Industry
in 72	potological		(Specify only highest grad	de completed)	(Give k	and of work done during most of a ONOT use retired)	working	-	n.oga n.ogovy
d with	8	5	Elementary/Secondary (0-12)	College (1-4or 5+)	leac	hers Aid	1	Baltin	one City
ai Hyg	9		17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle,	Maiden Sumame)
at yielitid A I A I 3000000 should be tiled within 72 hours atter deeth with the Maryland nd Mental Hyglene ornarked other then "natural", or iteme 23a or 28a-f show umatic event, the Medical Examinar must be motified at	1	_ 1/	Jearne B. Clark			Thebec	ca lin	ntson	
2 shows and in minimum.	4		1 a. Info ant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street and Number or	Rural Route Numbe	r, City or Town, S	2010
C, N l and leelth mm 27 her tr		-	Ocnice M. horete	2 / Laughter	A X I Z	Cunningham	Date Ui		Dity or Town, State
Pages in the not be not if its its or of bury or of or or or or or or or or or or or or or		4	1 Surial 2 ☐ Cremation 3 ☐	Removal from State	metery, crem	atory`or other place)			
			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		irriscn	Name and Address of Facility V	16.700+1	Occasion of	5 mills mo
Dealt. permit. Departr imports eny inje	Buce		No. 1		81		ad handa		
		+	23a. Part1. Enter the disease, or comp	plications that caused the death	. Do not ente				Approximate Interval Between
Physicia	an		shock, or heart failure. List only of Immediate Cause (Final		T. C	OLON CANC	-a		Onset and Death
/Medic			disease or condition resulting in death)	a. METASTA Due to (or as a consequ		DLON LANC	E1 .		
Examin	er		Sequentially list conditions,	p	NED	NA			
Z W #	1	5	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or).				
and and Ftrans	8	1	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):				
VII all MECOLIUS, P.O. BOX 00/00, sician: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	100								
ticate tphys	1	200		d					
OX OX or or or or or or or or or or or or or	1	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal				23d. Date	of delivery
death death of for	15	200	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at time of de		Ectopic pregnancy Other (specify)		Mont	th Day Year
et the	1	Ě	9 Unknown					12	
es th ligned be de	1		Part II. Other significant conditions co	ontributing to death but not resu	ilting in the un	derlying cause given in Part I.	_		bute to the cause of death? 3 □ Probably 4 □Unknown
w requires been sign	3	ם -		-			- 10		
Has b		Completed by					24a. Was autop	sy pr	/ere autopsy findings available nor to completion of cause of eath?
T. Th.							1 ☐ Yes	2 No 1	Yes 20 No
Sician: 1 sician: 1 certitica irector, p	9	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1 Inpatient 2	ER/Outpatient	Other	Death (Check only of g Home 5 ☐ Resid		r (Space)
9 Phy 9 r this eral d	1		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	7	now injury occurre	
nding ath. r: Afte	1	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	M 1 Yes 2 No			
LIVISION I or Attending etter death. Director: Atte		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	28f. Location (S City or Tox		or or Rural Route Number,
italo Set Distribed			V. 202002H						
LIVISION OF VIGIL IN TO THE HOSPITAL OF THE HOSPITAL OF A THE HOSPITAL OF THE		Medical	(Check only 2 Medical Exam	niner: On the basis of examinat		occurred at the time, date and places occurred at the time, date and places occurred at the control occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and places occurred at the time, date and the time, date at the tim			
the thin 2 the mplet		Ze -	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed	(Month, Day, Year)
₹ <u>₹</u> ₹ 8	/		= CXU cxin Jer	Mehta	M.0	D41410		MANUARY	06k 2007.
h		-	30. Name and address of person who	completed cause of death (Item	23a) (Type F				
9				SPITAL CENT		ANDAUSTOL		D 21	1133 .
	State	~	31. Date filed (Month, Day, Year)	32. Registrar's Signa		1		-	
Reg	istra	r	JAN 0 9	2007 Marie 18.	at the same of	100000			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-00089 State of Maryland / Department of Health and Mental Hygiene 2007 Thurman Johnson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 3, 2007 2339 hrs SO MNSON Medical Examiner CIARENCE ThurmAN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore** 123 W. 29th St 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Min. Months Days Hours Country) MA Director 1 X M 36 7146 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No 28a-f show Korylno must be notified at once. death with the Maryland Director 10g. Citizen of What Country 10e Street and Number 2/2/8 USA 29 23 W. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Specify: Bleck Yes Yes 2. No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 3 Widowed If Yes. Give Yea Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) item 27 is marked other than 'traumatic event, the Medical Private MD 21215-0036 struction Worker 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Torkes Be SUMMON larence 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAHGOR Baltonone THE 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Ξ partment o EME Ku 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bolhres's Nul KETS TENSTOUR Kd iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit executed Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 No 3 ✔ Probably 4 Unknown Emphysema, Asthma Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? certificate has Yes 2 V No Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifi 25. Was case referred to medica Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 1 V Natural 1 Yes 2 No Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide

within 2

OCMF 2006

31. Date filed (Month, Day, Year) Registra DHMH 17 Rev 1/2001

State

Medical

29a. Certifier 1

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

and manner stated

Assistant Medical Examiner

32 Registrar's Signatur

Declara.

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 4, 2007

Patient Known as Johnson, Linwood Lee Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Ple	ease	Type or Prin	nt in B	lack Ind	delible Ink	. Ensure A	II Copies	Are L	egible.	
		. For		State of Ma	aryland			lealth and I	Mental Hy	giene (2007	7 00234
		State Registrar				Cer	tificate of	Death		Reg. No.		
Physicia	ın	Decedent's Name (First, Min		-					2. Date of De Month	ath Day	Year	3. Time of Death
/Medic			33-	JOHN50	n -				Januar		2007	12:02 PM
Examin	er	4a. Facility Name (If not institu	_	· ·			-	or Location of Death	1	4c. Cc	ounty of Deatl	h
Funeral		Sina; Hospita 5. Social Security Number	6. S	ex 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year		8. Date of Bi	rth	9. Birtl	hplace (State or Foreign
Funeral Director		217 18 1062	1	№ M 2□F	85	Yrs.	Months Days	Hours Min.	(Month, Da	iy, Year)	Coi	my losso
pu ,		Usual Residence of Decedent			I 100 City	. Town or lo	antion		1			/
arylar show	_	10a. State 10b. Cou	nty	1.	10c. City	, Town or Lo	Aprisic					10d. Inside City Limits 1 ∑es 2 ☐ No
the M 28a-f otifie	Director	10e. Street and Number	-	11		13/11	10f. Zip Code			10a Citize	n of What Co	
leath with the Marylar ns 23a or 28a-f show must be notified at	<u></u>		con.	10 RUMP				215			SiA	anny.
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	11. Marital Status		12. Was Decedent	Ever in U.	S. 13. V		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No		Race - Amer	
ours after de Iral", or item: Examiner n		1 ☐ Never Married 2 ☐ N	larried	Armed Forces? 1 ★Yes 2 1 If Yes, Give			r Yes, specity Cub I∐ Yes 🌌 No		o Hican, etc.)	- 1	Black, White	
ours iral",	d by	3 Widowed 4 □ Divord	ed	Year or Dates:			1 Tes 2 110	ореслу.			pecify: 13/2	
"natu	lete	15. Deced (Specify only hig	lent's Ed thest gra	lucation de completed)		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of wor	king		of Business/I	Industry
withir ene. than	dmo	Elementary/Secondary (0-1:	2)	College (1-4or 5	5+)		cater	id)			UL J	uchen
filed Hygi other	Be Completed	17. Father's Name (First, Midd	lle, Last)	·		C/1/c/-	, . ,	18. Mother's Nan	ne (First, Middle	190		/
lid be lental ked c	To B	maluin &	NA	504				Ada	ROBET	H		
2 should and Meris marke is marke		19a. Informant's Name/Relation	onship (Type. Print)	/	1	-	and Number or Ru	_			
and 2 ealth a n 27 i		LINDA JOHASON	- In	itterick /0	neglik			rde lui	n ba	/ Theor	, Med	21211
- ± 2 ±		20a. Method of Disposition 1 → Burial 2 □ Crematic	n 3⊡	Removal from State	20b. Pi	emetery, cren	sition (Name of natory or other pla		Date		tion - City or	
. Pages tment of tant: If it		4 □ Donation 5 □ Othe	(Specif	r) _	AIBU	The MIG	nusical for	rh !	1/01	AYBU	TU, 1.	May/sas
permit Depart Import any in	-	21. Signature of Fundral Serv	Lice Lice	fee				ess of Facility CX			Na /	
1112		23a Part1. Enter the disease	or com	nlications that caused	I the death						Wa /	Approximate
.	_	shock, or heart failure.	ist only	one cause on each li	ne.			ing, odon do odrala	or reappratory t	.,,		Interval Between Onset and Death
Physician /Medical		Immediate Cau (Final disease or condition resulting in dilath)	-	a. hypon	aconsen	ience of):					-	1 day
Examiner				Sepsis								2 weeks
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to (or as		uence of):						
e executed	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c								
De execian a	_	resulting in death) Last		Due to (or as	a consequ	uence of):						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica			d								
death certificate attending physi	/Me	IF FEMALE:		23c. If yes, outcome	pf pregna	ncy				230	d. Date of deli	iven
atten atten I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	l death 3	Ectopic pregnand Other (specify) _	ey .		250	Month	Day Year
at the de by the a	hysi	9 Unknown		9□ Unknown								
res that signed t	by P	Part II. Other significant con-							23e. Did	tobacco use	contribute to	the cause of death?
w require been sign should b	ed k	respiratory t	ailu	re, Diabe	tes 1	nell.tu	S, Deep v	ein	1 🗆	Yes 2□	No 3∏ Pr	obably 4 Unknown
has bei	plet	thrombosis,	_Chr	unic Obstru	other 1	Pulmon	and diseas	4	24a. Was			itopsy findings available completion of cause of
The ate h	Completed	'					/		perf 1∐ Yes	ormed? 2 X No	death? 1 ☐ Yes	
cian: ertific	Be (25. Was case referred to med examiner?	lical	I I nomitale			Tau	26. Place of Dea	th (Check only	one)		
Physi this o	ပ္	1 Yes 2 No 27, Manner of eath		Hospital: 1 Inpatie		ER/Outpatien 28b. Time of	1 3 DOX		lome 5 Res			cify)
ding l	ion	1 Natural 5 □ Per	nding estigation	(Month, Da	y Year)	Injury	Wo	iryat irk?]Yes 2.⊟No	28d. Describe	now injury o	occurred	
Attende de att	fical	3 Suicide 6 □ Cor	uld not be ermined	28e. Place of inju			eet, factory, office		28f. Location	Street and I	Number or Ru	ıral Route Number,
al or after after al Direction	Certification:	4 ☐ Homicide det	Smilliod	building, et	c. (Specify	V)			City or To	wn, State)		
ospita hours unera ly fille				nysician: To the best								
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only 2 Medi	cai Exai	niner: On the basis o and manner st		tion and/or in	vestigation, in my	opinion, death occi	arred at the time	, date and p	ace, and due	e to the cause(s)
To t To t	Σ	29b. Signature and title of cer	tifier				29c. Licen		i	29d. Date s	signed (Month	h, Day, Year)
		Megh	~~	MA			_ KE	5-000)	Janu	a-7 3,	2007
10		30. Name and address of pers	son who	completed cause of d	leath (Item	23a) (Type,	Print)	S-000 altimore			, ,	,
- 01	•	31. Date filed (Month, Day, Ye	oan)	1 32. Be gistr	ar's Signa	Hospitare	al ot Bo	altimore				
Sta Registr		TARE A	10 4	0007			and a					
		JAN (1 3 /	WIII J. J. J. J. J. J. J. J. J. J. J. J. J.	Acres 1	No. of the last of	100					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Carroll Eugene Joynes, Jr. **Physician** January 8, 2007 1:12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days 1 M M 2□F Months 217-20-5373 79 March 17, 1927 Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 MNo MDBaltimore Phoenix Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10 Sunnyview Dr. 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No SpecifyWhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printing Production Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll Eugene Joynes, Sr. Estella E. Klingenstein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy A. Joynes-Wife 10 Sunnyview Dr. Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 W Burial 2 □ Cremation 3 □ Removal from State Moreland Cemetery 4 □ Donation 5 □ Other (Specify) 1/12/2007 Parkville, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation 21. Son ture of Fundal Service Licentee 2325 York Rd. Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician Due to (or as a consequence of): /Medical Examiner 'ardi armopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of): ttending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hor Water 24a. Was an autopsy performer 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ÖRIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D20907

To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the "ttending physician and Division or Vital Records, P.O. Box 68760, completely filled in by the funeral director,

3altimore, Maryland 21215-0036

natham Marie 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

(Rate

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6761 N Charles St. Bettinone, Md 21204

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylan	•	tificate of			g. No.	
			Decedent's Name (First, Middle, La	st)				2. Date of Death	David Maria	3. Time of Death
	Physici /Medi		Wilson D. Jone	S				January	^{Day} 2 2007	1:00 A M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
100			Knollwood Mano	r		Miller			Anne Ar	unde1
	Funeral Director		239-40-6446	The off	last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 9	9. Birthr 1927 N.	place (State or Foreign ntry) Carolina
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	action				10d. Inside City Limits
	aryla ehov	5				Callon			1	1 ☐ Yes 21 No
	the Marylar 28a-f ehow	ecto	Maryland Anne A	runder A	rnold	1017 0-1-		10	- Ciri (1Mb C	
	th with t	Funeral Directo	10e. Street and Number 57 Old Frederi	ck Rd.		10f. Zip Code 21	012	10	g. Citizen of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f show striputy or other traumatic event, I'm Mealical Examinar must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes X No	dispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- tican, etc.)	14. Race - Americ Black, White,	etc.
5-0	72 hc	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Dece	dent's Usual Occup	nation during most of working	1	6b. Kind of Business/In	dustry
21215-0036	within lene. then	Completed	Elementary/Secondary (0-12) 4th	College (1-4or 5+)	lite.	DO NOT use retired teel Wo	d)		Bethleham	Stee1
	filled Hyginather	Ö	17. Father's Name (First, Middle, Last				18. Mother's Name			
an	id be ental ked o	To Be	Luther Jones				Mary Ly	ons		
Maryland	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State, Zig	Code)
Ž	nd 2 lith a 27 te r trat		Jeanette Stree	t(Niece)	5837	Sandst	one Dr.	Durham,	N.C. 27	713
Baltimore,	ages 1 au ont of Hea t: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Ji toilloval ilolli State	lace of Dispo	sition (Name of வர்ற ் r other place 1 Park		ate 2	oc. Location - City or To Annapolis	own, State
Ė	artme ortan injur		21. Signature of Funeral Service Lice						ary, P.A.	, 114.
Ba	Department of the partment of		Larry S. Re						Md. 2140	0.1
- 2	A A		23a. Part1. Enter the disease, or com	plications that caused the death						Approximate
	Physician /Medical Examiner		shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		sch	- arher,	slero	1.4	Intervat Between Onset and Death
	Dov #	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):			-		
	physician and sthe burial-transit	Eam	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	be ex	E		Due to (or as a consequ	uence or):					
87	cate I	dica		d						
Box.	death certif e attending id for use e	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliver	ery Day Year
P.0	that the	F.	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
ords,	w requires that the been signed by th should be detache							1 ☐ Yes	2 No 3 Prot	oably 4 Unknown
I Records,	The law ate has b page 2 si	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available impletion of cause of 2 No
/ita	Physician: rthis certific ral director.	Be	25. Was case referred to medical examiner?	111		- Lau	26. Place of Death	Check only one		-
of	hysi this o	2	1 ☐ Yes 2 ☐ No		ER/Outpatier		Nursing Hor		nce 6 □Other (Specif	(y)
u	After unera	on:	27. Manner of Death 1 → atural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		8d. Describe how	v injury occurred	
Sic	Attending of death.	cat	2 Accident investigation 3 Suicide 6 Could not be	10			Yes 2 □No	Of Location (Ctr.	eet and Number or Rura	-1 Courte March
Division of Vital	after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	xme, iarm, str /)	eet, factory, office	2	City or Town,		ai Houte Number,
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C	29a. Certifier 1 Pertifying Pl (Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, deati tion and/or in	n occurred at the till vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the car d at the time, da	use(s) and manner as s te and place, and due to	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and tille of certifier	Cun		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
7	4		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)	37136		1/2000	
19	Sta	ate.	31. Date filed (Month, Day, Year)	32. Segistrar's Signa	ture	مان ران	. me C	Miter o	-03 02/6	7
	Regist		JAN 0 9	2007 Desce 1	or for	and in				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #19b, perFh, So31/9/0/land / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Allen Johnson Edward JANUARY 5. 12:30AM 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Months Days Hours Min 1**⊠**M 2□F 4 Yrs. 231.32.0757 05. DZ. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4705 Woodlea thenua 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify. þ 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver 1 ransportation 9th grade N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aura Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) taulette Johnson 4705 Woodlea Avenue, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gamson Forst Owings Mills MD 01.12.07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughin C. Greene Funeral Services 49105 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BACTERIAL PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if 2 y, beauting to him evaluate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as been signed by the attending papers bould be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) Tyes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an HYPOTENSION autopsy 1□ Yes 2 X No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No death. 2 Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: 3 ☐ Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PANUARY DR551 D 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSROW TABASSI M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Marylar		artment of H			giene 00	7 00238
Physici /Medic		Decedent's Name (First, Middle, Last) Young Su Kim					2. Date of Dea Month	Day	Year 3. Time of Death
Examin	er	4a. Facility Name (If not institution, give street 1077 Largo Road, Ap 5. Social Security Number 6. Sex	·	(not biothele vi)	4b. City, Town, or Upper N	Location of Deat	h	4c. County o	icoraes
Funeral Director			1 2 F 83	Yrs.	Months Days	Hours Min.	3/24/19	r, Year)	Birthplace (State or Foreign Country) Korea
Maryland a-f ehow	ctor	MD 10b. County Prince George	~~	ty, Town or Lo per Ma:					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the M 3a or 28a-f	I Director	10e. Street and Number 1077 Largo Road, Apr	- m 01		10f. Zip Code			10g. Citizen of Wi	
ind Z 1 Z 1 Z 2 Z 2 Z 2 Z 2 Z 2 Z 2 Z 2 Z 2	by Funeral		Was Decedent Ever in U Armed Forces? 1	1	20772 Was Decedent of Hi I Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, s, White, etc.
within 72 hou jiene.	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Give	tent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Bus	
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men	0	12 17. Father's Name (First, Middle, Last)			Homemaker		me (First, Middle,	Own Hon Maiden Sumame	
d 2 should be filed the and Mental Hyg	To B	Hong Jae Kim 19a. Informant's Name/Relationship (Type)	Print	405.14		Jung Hw			
T and t and Health em 27 ther tr		Duk Bae Kim/Son 20a. Method of Disposition		9200 I	ng Address (Street a Paloma La sition (Name of	ne Spri	ngfield,	VA 2215	
Pages nent of s ant: If It		1 ☐ Burial 2 【XCremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	IOVALITORI STATE	cemetery, cren ro Cren	sition (Name of natory or other plac natory	1/10		Catonsvi	
or the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. Or the Funerel Director: After this certificate has been signed by the attending physicien and ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	23a. Pan*. Enter the diseas or composations, or heart lailure. List on incomposations or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consect	yo Cav Junce of): A Car Juence of):	active mode of dying additional control of the second of t	refarch	ton ung Ca		Approximate Interval Batween Onset and Death, G All imms
that the death certificated by the attending problem of the delached for use esti	hysician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
w requires that been signed b	by P	Part II. Other significant conditions contrib	outing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to		bute to the cause of death? 3 Probably 4 Unknown
n: The law requireste has been r. page 2 should	Completed						24a. Was a autop: perfor 1 🗆 Yes	sy pri męd? de	fere autopsy findings available for to completion of cause of eath?
iding Physician: The la	itlon: To Be	1 162 5 MINO	pital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c, Injury Work	er: 4 🗆 Nursing H		ence 6 □Other ow injury occurred	
To the Hospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicido 6 Could not be	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, factory, office		281. Location (S City or Town	treet and Number n, State)	r or Rural Route Number,
ne Hospit n 24 hour ne Funere	Medical (29a. Certifier (Check only one)	an: To the best of my kno On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occu	a, and due to the coursed at the time, d	ause(s) and mani late and place, an	ner as stated. nd due to the cause(s)
To t Withi To tl	Σ	29b. Signature and title of certifier	S. ME) ,	29c. License			-	(Month, Day, Year)
6		30. Name and address of person who comp	eleted cause of death (Item	n 23a) (Type, I	Print)	Cinte 30	of Lan	ham 1	MD 20706
Sta Registr		31. Date filed (Month, Day, Year)	32. Regislrar's Signa	ature	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O3 **Physician** Pauline May Kluka 2007 January /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Saltimore N/AIf Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, DEC 6, 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔽 F 79 Yrs. 1927 Maryland 213-26-0264 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Locetion 10a. State 10b. County 10d. Inside City Limits MD N/A Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 933 Wilmington Ave 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items edical Exaπiner m 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Paul A. Thompkins Agnes M. Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Thompkins/Son 239 Hammonds Lane Brooklyn, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/8/07 Glen Burnie, MD 21. Signature of Fuperal Service Licensee MacNabb Funeral Home, P.A. C. Todd Dring 301 Frederick Rd Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (Ir as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Aortic the burial-trar Due to (or as a consequence of) Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1□ Yes Division or Vital To the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 XNatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation within 24 hours arter com...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) person who completed cause of death (Item 23a) (Type, Print)

2 dearmenci 700 . Name and address of

MEIN &

State Registrar Masan 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

32. Begistrar's Signature

2 degirmenci

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** : 38PM John C. Krause, III 6 January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F Yrs. 215-44-2396 Director 58 Sept 17, 1948 Maryland Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at XXYes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3604 Chestnut Avenue 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or itsma 23a any highry or other treumatic event, the Madical Examinations once. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Warehouse Pepsi Bottling Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Krause, Jr. Betty Hubbs ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3604 Chestnut Avenue, Baltimore, Maryland Barbara Ann Krause Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 1/9/2007 5 Other (Specify) 4 Donation Catonsville, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licensee Henss 21211 23a. Part1. Ebler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADRENAL INSUFFICIENCY **Physician** 1 week /Medical Due to (or as a consequence of) Examiner TASTATIC LUNG CARCINOMA 7 montrus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ·HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Michael OBSTRUCTIVE PULMONARY CHRONIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation s efter death.
It Director: Aft
id in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funersi C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT 2438946 MO January 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \mathcal{O}_{f} ACUMAZ MO Minor Manoral Hogyal SUPNEET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Mostle Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	1 - For State Registrar	State of I	Marylar		artmer <i>rtificat</i>			and M		giene	200	17		241
		é	Decedent's Name (First, Middle, Last	t)							2. Date of De	ath			3. Time	of Death
	Physici /Medio	_	Olivia Wade Knick	man							Month Jan.	7, Day	200	07	12:	:50P ^M
	Examir		4a. Facility Name (If not institution, give				4b. City,		Location o			4c.	County of	Death		
			Baltimore Washing						Bur				ne Ar			
· <u>Ž</u> .	Funeral Director		210 07 0300	9X 7. □ M 2 🟋 7.	Age (In yrs.	last birthday) 7 Yrs.	Months Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Oct. 3,	th 191	9). Birthpla Country	ce (State y) MI	or Foreign
000	M 1		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							100	d. Inside	City Limits
1215-0036 with the Maryland	-t sh	ţō	MD Anne Aru	nde1	Se	evern									1	s 2 No
d c	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wh	at Countr	y?	
3	238 0	a D	8154 Silo Road				21	144				U.S	.A.			
9	Su Su	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race -	American White, et		
36	or it	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 [If Yes, Give	X No	1	1 ☐ Yes		Specify:		,		Specify:	Whi		
000	lure!	d b	3 X Widowed 4 ☐ Divorced	Year or Date	s: 	16a. Dece	dont's Llau	al Casusa	tion			165 K	nd of Busin		-1	
15	"na" (Completed	(Specify only highest gra	de completed)		(Give	kind of wo DO NOT u	rk done d se retired)	u <i>ring</i> most	t of workii	ng	100. K	riu oi busii	nessindu	stry	
212	r the	E O	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Home	e Mak	er				C	wn Ho	ome		
ם פ	othe	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)			
arylar	Menta Menta ific e	5	Andrew P. Wink						Mar	ie D	owney					
Maryland 21215-0036	and I	. 3	19a. Informant's Name/Relationship (-				/ Route Numb	-		ate, Zip C	ode)	
2 50	and ealth m 27		Mr. Earl Knickman	Jr./Son					ad S		n, MD 2					
Baltimore,	r of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		Place of Dispo cemetery, crei	nsition (Nai matory or c	me of other place)		. 10,	20c. Lo	cation - Ci	ty or Tow	n, State	
	tmen tant:	١,	4 □ Donation 5 □ Other (Specify		G.	len Hav				2	007		Burn			
Bal	permit. Tagges I amou Stroud be liew within 12 flouds also death with the maryian population of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!", or items 23a or 28a-f show eny injury or other traumatic event, if a Modical Examinal miss is a notified at once.		21. Signature of Funeral Service Licen	vere	Moi.		2. Name ar L Sec			OL	ngletor Glen F	ı Fun Burni	eral .e, M	Home 210	e, P. 061	, A •
A SOUTH AND	hysician by specifical by sician and by sician street by	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for	as a consequence as a c	uence vI).	, 		200		1216					
Box 6	e ettending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Feta at time of d	ıl death 3 [Ectopic p						23d. Date o Month	,	ay	Year :
ords, P.O	5 5	þ	Part II. Other significant conditions of	-	n but not res	ulting in the u	nderlying o	ause give	n in Part I.				se contribu ⊒No 31			death?
COL	- 0.76	ete									24a. Was	20	24h Wa	re autons		s available
of Vital Records,		Completed									autor		prio	or to comp th?	No No	cause of
of Vita	yalcını. is cərtific director,	Be	25. Was case reterred to medicat examiner?	Hospital:		50.0		Othe			(Check only o					
o d	r this aral di	To To	1 Yes 2 No 27. Manner of Death	28a. Date of le	njury	ER/Outpatier 28b. Time of		28c. Injury Work			ne 5 Resi					
On	th. : Afte	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, i	Day Year)	Injury	м		? 'es 2□N				,			
Division Lor Attending	after death. Director: A I in by the fu	Certification:	3 Surcide 6 Could not be determined	28e. Place of	Injury - At he		reet, factor	y, office		2	28f. Location (: City or To			or Rural F	Route Nu	mber,
atiosof	4 hours Funeral	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basis and manner	of examina	owledge, death	h occurred vestigation	at the tim	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and mann place, and	er as stat d due to th	ed. he cause	(s)
4	within 2 To the Complet	Me	29b. Signature and title of certifier				29	c. License	number			29d. Dat	e signed (/	Month, Da	ay, Year)	
	<i>y</i> = 0		Mc MA	(A)	my	,	ż	0	337	21		01	07	, 2	oron	7-
•			30. Name and address of person who	ompleted cause of			Print)	35	0	or	3.8177	37	· n	- SZ.A	VE	,
	7		MAJEROS	F100	K	m	2	CNE	en	r	5 8 1 7 7 3 mg	VIE	5	20	210	1 de
	Sta Registr		31. Date filed (Month, Day, Year) JAN 09 2007	32. Regi	strar's Signa	ature	20									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryla		artment of Hertificate of L			giene	7 00242
	* 5	3	Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physici /Medi		Shirley Louise Klett				Januar		7 2:40 A ^M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death	4c. County of	
	# 	14.6	Upper Chesapeake Medical Cente	er	Bel Air			Harf	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yr 1 1 M 2 XF 77	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birt (Month, Da) Mar. 31	y, Year)	Birthplace (State or Foreign Country) Oregon
	pug *	}	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation			75-47	10d, Inside City Limits
	Aarylan I ehow	5		Bel Air					1 □ Yes 🏖 No
	or 28a-1	Director	10e, Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
	th with 23a or	0	127 Briarcliff Lane		21014			USA	
36	tams recm	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:			spanic Origin, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race	- American Indian, K. White, etc. White
	"natural", or	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bus	
215-0	hin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired;)	of working		
2C	giene grene	Completed	7	Rese	arch/Write	er		U.S. Go	overnment
nd	2 should be filed withir and Mental Hygiene. Is marked other then surnatic event, the Mi	Be (17. Father's Name (First, Middle, Last)				s Name (First, Middle,		»)
<u>√</u>	should ind Men marke umatic	ျှ	John Dickinson Hertz				a Ethel Wo		
Maryland	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hygiene If item 27 is marked other then 'natum or other traumatic event, the Madical	14.5	19a. Informant's Name/Relationship (Type, Print)		-		or Rural Route Numbe le, Bel Air		
	1 and Health em 27 ther tr		James Klett/Spouse 20a. Method of Disposition 20b	. Place of Dispo	sition (Name of		Date Det All		City or Town, State
∪ / more,	Pages nent of I nnt: If its		1 ☐ Burial 2 🗷 Cremation 3 ☐ Permoval from State	cemetery, crei	matory or other place	1	1		
a c		1	4 Donation 5 Other (Spingly) 21. Signature of Fundations III nase	-	Service Co 2. Name and Addres	-	_		Maryland
Ba	permit. Departimonto importa eny injude.		The KING	Mk	Comas Fur	neral'	Home, P. A	lon Mara	land 21009
			23a. Part1. Enter the disease, or complications that caused the de						Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	De Co	.01110				Onset and Death
40	/Medical		disease or condition resulting in death) Due to for as a cons	equence of):	une.				- mays
	Examiner		Samuel In Chromic	obsmic	hive Du	more	aus Direct	00	
	₽ .≡	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):		•	9		
B	ste be executed hysicien and the burial-transit	Examiner	that initiated events c.						
8760,7	ste be exemple the string string string the burial.	Ē	resulting in death) Last Due to (or as a cons	equence of):					
		dicai	d						
Box 6	The law requires that the death certific the has been signed by the attending Foogle 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 Yes 2 No 23c. If yes, outcome of pregnant in the past 12 moorts? 4 Pregnant at time of the pregnant in the past 12 moorts?	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
20	at the by th	hys	9 Unknown						
ecords, I	en signed	5	Part II. Other significant conditions contributing to death but not in the significant conditions contributing to death but not conditions conditions conditions contributing to death but not conditions condit	esulting in the u	inderlying cause give	on in Part I. D1 SCO	23e. Did to	1	bute to the cause of death? 3 Probably 4 Unknown
Reco	To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed	Dementia, Malnutrid	M			24a. Was autop perfo	rmed? pi	ere autopsy findings available nor to completion of cause of eath? Yes 2 No
<u> </u>	ician: Th certificate rector, pag	Bec	25. Was case referred to medical	7.0		26. Place o	of Death Check only o		
	Physician: this certific ral director,	5		☐ ER/Outpatie	nt 3 DOA Othe	er: 4 ☐ Nurs	ing Home 5 Resid	dence 6 □Othe	r (Specify)
	ding Phys	ü	27. Mann Death 28a. Date of Injury (Month, Day Year,	28b. Time o Injury	Work			now injury occurre	id
Sion	ttending death. ctor: After y the fune	cati	2 Accident investigation			Yes 2 No			
13	or All after of Direction by	Certification;	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t nome, tarm, st <i>ecil</i> y)	reet, factory, office		City or Tox	vn, State)	er or Rural Route Number,
1	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my l	rnowledge, deat	h occurred at the tim	ie, date and	place, and due to the	cause(s) and mar	nner as stated.
	1 24 h	Medical	(Check only 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my op	oinion, death	occurred at the time,	date and place, a	nd due to the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	1 -	29c. License	number		29d. Date signed	(Month, Day, Year)
			Illul IIII mik	en	Hoo	62	765	1/5/20	207
	10		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print)		001	1	0.01=1
			Nesseen Kurton, U.O. 50	Ollops	erunesa	peak	wr.isel	AIC, IN	171014
[8	St Regist	ate rar	31. Date filed (Month, Day, Year) 32 Registrar's Signature 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	J. And	and o	•			

		1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>			giene Reg. No. 2	07	0021.2
E +	*		1. Decedent's Name (First, Middle, La	st)				Date of Dea Month	ath Day	Year	3. Time of Beath
4.	Physici /Medic			Pete	r Kelly				nuary 4, 20		6:40 p M
	Examin		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			83	45 Kings Height	s Road		Ellic	cott City		Ho	ward
£11-m9	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v. Year)	9. Birthpla	ace (State or Foreign
	Director	9		1□ ¥ 2□ F	62 Yrs.	Monaio Bayo			8 1944		NY
	D		Usual Residence of Decedent		10. Oit. T					110	d. Inside City Limits
	irylar show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10	1 □Yes 2 No
	e Ma Ba-f s	cto	1110011 1101111	Howard			llicott City				/ .
	iff th	Dire	10e. Street and Number			10f. Zip Code	04040		10g. Citizen of W	vnat Counti U.S	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther the Medical Examiner must be notified at	Funeral Director	8345 Kings Heights F				21043		14 Dags	e - America	
	r dea	ne	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black	k, White, e	
98	or it	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give	0	1 ∐ Yes 2 ∐ X o	Specify:		Specify.	*	White
215-0036	ural' ural'		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	163 Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Indi	ustry
5	"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing			•
121	vithir ane. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5-	+)				Inte	ernation	al Freight
121	lled \ lygie ther i		17. Father's Name (First, Middle, Last	1		Busir	ness Owner 18. Mother's Nam	e (First, Middle,	Maiden Surnam	ne)	-
ano	ntal l ed oi	Be	Tit i dallot o ridanio (i mai, mazaro, asse	,				-	anina Cifa	k	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	၉	\A/illi 19a. Informant's Name/Relationship	Cittle Committee	19b Maili	na Address <i>(Street a</i>	and Number or Rui		Regina Sife er. City or Town.		Code)
Na	d 2 sl th an 7 is r traur				1	8345 Kings H					•
	1 and 2 Health tem 27 i		Ms. Debra Ke 20a. Method of Disposition	eliyS	20b. Place of Dispo cemetery, cre			Date	20c. Location -		vn, State
Baltimore,	of of		1 ☐ Burial 2 ☐ Cremation 3 [cemetery, cre	matory or other plac	1				
ŧΪ	t. Partmer rtant rtant		4 Donation 5 Other (Special Control Special Inc.	//	Long Iş	land Crematic	on Colliny	/10/2007	West	Babylor	n, New York
3al	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice		_ -		Funeral Hon	ne PA			
500	402.00		2 Part 1. Enter the dise se, or con	Lec moo	the death. Do not on	3871	Old Columbia	Pike Ellic	ett City, MD	21043	Approximate
			snock, or near tallere. List only	one cause on each lin	e.						Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Squan	con Cell	Cancer	of hers	land	heck	- 4	1 years
-6	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):		V				
	LXummer		Sequentially list conditions.	b.	a consequence of).					-	
	pe sit	je	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence or,						
	ecut and I-tran	Examiner	that initiated events resulting in death) Last	c	a consequence of):						
8760,	cate be executed physician and the burial-transit	E			,						
87	cate ohysi	dical		d	<u></u>						
9	ertific ding p	Physician/Me	IF FEMALE:	23c. If yes, outcome	nf pregnancy				22d Dal	te of delive	n/
Box	death certifi e attending d for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death 3	Ectopic pregnancy Other (specify)	у				Day Year
	w requires that the death certifit been signed by the attending I should be detached for use as	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	ume of death 5	Other (specify)					
P.0	that the ed by detac	Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to th	e cause of death?
S,	res tl signe lbe c	by	Tarin only significant contains		,	, ,		1,80	Yes 2 No	3 ☐ Prob	ably 4 □Unknown
Records,	requires een signe hould be	Completed							T		Codlesson sitely
၁	E S C	Jple						24a. Was	psv I i	were autor prior to con death?	osy findings available npletion of cause of
H	ate pag	ပ္ပ						1□ Yes		1 ☐ Yes	2 2 No
/ita	ysiclan; is certific director,	Be	25. Was case referred to medical examiner?	11		104	26. Place of Dea	th (Check only o	one)		
7	<u>≥</u> . <u>≤</u>	ို	1 ☐ Yes 2,EKNo		nt 2 ER/Outpatie		4 🗆 Nursing n		dence 6 □Oth)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. Time (/ <i>Year</i>) Injury	Wor		28d. Describe	how injury occur	red	
Si	Attending r death. ector: After	atic	2 ☐ Accident investigation				Yes 2 □ No	00(1 1)			I Don't Alicenter
Division or Vital	or Ath	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At home, farm, s c. <i>(Specify)</i>	reet, factory, office			Street and Numb wn, State)	oer or Hura	I Houte Number,
		Se				th conversal at the co	ima data and al-	and due to the	ogues/s) cod	annor es es	ented
	Hospital 4 hours a Funeral tely filled	cal	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	f examination and/or i	nvestigation, in my	opinion, death occu	rred at the time	, date and place,	and due to	the cause(s)
	the the mplei	Medical	29b. Signature and title of certifier	and manner sta		29c. Licens	se number		29d. Date signe	d (Month.	Day, Year)
	7 ¥ 5 00	-	250. Oignature and title of certifier	/ m		DI	203745	8	1/4	1/2	007
	10		11mdb	3			,,.,	-		11	
	(o 0		30. Name and address of erron wh	o completed cause of d	eath (Item 23a) (Type	, Print)	CDC	+ R.	4 L	. 0	7 1201
	*		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	evel 11	s, vaca 8	1. Del	amoir,		21201
*	St Regis	ate trar	JAN 0 9 200	7 Result	eath (Item 23a) (Type						

		1	For State Registrar		State o	of Maryla	and / [-	rtment			and M		Reg. No.	200	17	002	ĻĻ
/M	sicia edica	n il -	I. Decedent's Name (F	n		mber)		L	ESS 4b. City		Location o	of Death	2. Date of De Month	Day 2	200 200	7	3. Time of Death	М
Fune			The John 5. Social Security Number 217-66-5	S HOP		7. Age (In y	rs. last bii	thday) Yrs.	Ba If Under Months	Itim		City	8. Date of Bird (Month, Da			N/	A ace (State or Fore	ign
g			Usual Residence of De 10a. State 10 Maryland	b. County	N/A	10c.	City, Tow	n or Lo	cation	В	altimore	9				10	0d. Inside City Lim 1 Yes 2 1	
th with the 23a or 28a	181 08 180	al Direc	10e. Street and Number 921 North C		reet				10f. Zip		212					U.S.A	Ą.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 21 is marked other than "natural", or tems 23s or 28s-1 show minimized to the resummits asset.	Example: m	by Fur	11. Marital Status 1		Armed F	2 □X No ive	ı U.S.		Vas Deced Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe 1, Puerto I	ecify Yes or No Rican, etc.)		4. Race - / Black, \ Specify:	White, 6		
Maryland 21215-0036 td 2 should be filed within 72 hours att lith and Mental Hygiene. T? Its marked other than "naturel", or	In Medical	Completed	15 (Specify Elementary/Seconda 12		rade completed,	(1-4or 5+)	16a	(Give	lent's Usua kind of wo DO NOT us	rk done d e retired,	lurina mos		ng	16b. Kin	d of Busin Priva		ompany	
Vland	atic event,	To Be C	17. Father's Name (Fir		st) o Lessane									e Barr	Lessar			
and 2 sho ealth and m 27 is m	ner traum		19a. Informant's Name William Less	sane Son		201		3	g Address 389 Ma sition (Nan	son C	ourt Ba	altimor	d Route Numbe e, Marylan Date	d 2123	Town, Sta			
Baltimore, bermit. Pages 1 ar Department of Hea Important: If Item	njury or of		20a. Method of Dispos 1 ☐ Surial 2 ☐ C 4 ☐ Donation 5 [Cremation 3 ☐ Other (Spe	cify)	- 1	cemete	ny, cren M	Zion (ther place Cemet	ery		01/09/07	i	Lansdo		Maryland	
Depa d	once		23a. Part1. Enter the	ul	M. I	caused the d	eath. Do						eral Service altimore, N		17		Approximate Interval Between	
Physici /Medic Examin	cal ner	Examiner	shock, or feart fi Immediate Cause (Fir disease or condition resulting in death) And the standard of the stan	nal	a. Er	o (or as a con:	sequence		r D'is	SCC.	ol .						Onset and Death 2 Years	
death certificate be executed attending physicien and	<u> </u>	ca	that initiated events resulting in death) Las		c. Due to	(or as a con	sequence	of):										
at the death certific by the attending pl	ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pi in the past 12 mo 1 Yes 2 N 9 Unknown	onths?		birth 2 ☐ f nant at time	etal deatl		Ectopic pr Other (sp				- ilicratio	2	3d. Date o Month		nry Day Year	
- E D	9	2	Part II. Other significa	nt condition	s contributing to	death but not	resulting	in the u	nderlying o	ause give	en in Part I		23e. Did 1				ne cause of death? ably 4 🔲 Unkno	
	page 2	Completed											24a. Was auto perfo 1 ☐ Yes		prio dea	r to cor	psy findings availa mpletion of cause 2 No	
of Vital Physician: this certifical	rector	Be	25. Was case referred examiner?		Hospital:					Oth	or		(Check only					
Phys	- 0	၉	1 ☐ Yes 2 No.		28a. Date	Inpatient :	28b.	utpatier Time o		28c. Injun	4 140		me 5 Resi 28d. Describe			Specify	V)	
Attending death.	y the fune	Certification:	1 XNatural 2 ☐ Accident 3 ☐ Suicide	5 Pending investiga 6 Could no determin	tion (Mo	nth, Day Yea	r) At home, f	Injury	м	1 🗆	k? Yes 2 □	No	28f. Location (Street and	i Number	or Rura	l Route Number,	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	aly filled in l		4 Homicide 29a. Certifier 1 (Check only 2)	☑ Certifying	Physicien: To the	ding, etc. (Sp	knowledg	je, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s)	and mann	er as st	tated.	
To the H within 24 To the F	сотріет	Medical	29b. Signature and titl Muj	le of certifier		nner stated.				c. Licens	e number			29d. Date	signed (/	Month,	Day, Year) 2007	-
2				atem	ti, The J	ohns Ho	PKINS	(Type,	Print)	4000	loven V	voiles	Stieet, B	altimo	re Man	ylan	d 21287	
Re	Sta gistr	ar	31. Date filed (Month,	Day, Year)		P⊕gistrar's S		A	reserved to	P								

			For State	State of Marylan					2007	00015
			Registrar		Cel	rtificate of L	Death	2. Date of Death	. No	3. Time of Death
	Physicia		1. Decedent's Name (First, Mide	dle, Last)		1 -		Month	Day Year	12:59 M
	/Medic	al	+ ANNIE	CourTrey		Lee		SANGA	Ky 6,2007	
	Examin	er	4a. Facility Name (If not instituti	0		4b. City, Town, or	Location of Death		c. County of Death	1
			Gensis L	Ang GREEN	In the last of the sale	If Under 1 Year	MOTO If Under 24 Hrs.	8. Date of Birth	N/A	place (State or Foreign
	Funeral		5. Social Security Number	6. 96x 7. Age (In yrs. 1 ☐ M 2 ☐ F 6 6	Yrs.	Months Days	Hours Min.	(Month, Day, Y	Year) Cou	intry)
Ц.	Director	-	215-28-7060 Usual Residence of Decedent	70				MARCHI	1.1908	V 1/7 .
	and and		10a. State 10b. Coun	ty 10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl f ehc	ō	m.D.	0/1	BAI	timore	,			1/2¥es 2□No
	28a-	ect	10e, Street and Number	11//-	75 . 7	10f. Zip Code		100	g. Citizen of What Co	untry?
	with so a	٥		newood Ad		211	120		2 .	1
	deeth with the Maryland ms 23a or 28a-f ehow r rust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race · Amer	
	ter d	F	t ☐ Never Married 2 ☐ Ma	Armed Forces? arried 1 ☐ Yes 2 ☑ No				Rican, etc.)	Black, White	,
21215-0036	n 72 hours after deeth with the Marylan "natural", or Items 23s or 28s-f show edical Examinal must be notilied at		3 Widowed 4 □ Divorce	If Vac Give		1 □ Yes 2 □ No	Specify:		Specify: B/	ACK
ð	2 hot	Completed by		ent's Education		dent's Usual Occup			6b. Kind of Business/I	ndustry
715	within 7 ene. than "n	pie	(Specify only nigr Elementary/Secondary (0-12	nest grade completed)) College (1-4or 5+)	life.	DO NOT use retired	di)	9	,	
2	70 75 7	E O	5th GRADE		<u> </u>	Do ma	stic Wi		Cleanin	g Hames
	be filed ital Hygi id other	Be	17. Father's Name (First, Middl	e, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	/
<u>la</u>	Alenta Alenta Treed	<u>ا</u>	Chris	Dyek			FANNI	e Le	C	
Maryland	d 2 should th and Mer 7 ie marke traumatic	2 8	19a. Informant's Name/Relatio	nshi (Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State, Z	ïp Code)
≥ `	and 2 nalth n 27 i		SilvA a	Right	89.				10. m)	.21/33
ore	es 1 an of Heal fitem 2 r other		20a. Method of Disposition	n 3 Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other place		Date 20	Oc. Location - City or	Fown, State
Baltimore			4 □ Donation 5 □ Other		ebut	us Mem	PK JAN	11.2007	Albutus	m
a	permit. Pag Department importent: eny injury conce.		21. Signature of Funeral Service	ca.Licensee	2	2. Name and Addre	ss of Facility	n al 1+0	me-	2/2/3
m	Per Per Per Per Per Per Per Per Per Per	2.4	of alth	W Bills		1129	VICACOLI	'nc st	BACTO.	nD.
			23a. Part1. Enter the disease,	or complications that caused the dealist only one cause on each line.	th. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Pnysician	8	Immediate Cause (Final disease or condition	Connec	Del .	28 trans	dillo	20		Onset and Death
4	/Medical		resulting in death)	a. u y to (or as a consec	que of):	and g	A-	^	00	
	Examiner		C	2 Phones	VO	bestul.	live It	Junery	Olifer	e
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Die o (or as a consec	quence of):		- 1	1	2530	
	ransi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	1 . Then	ina			V		
o,	e be executed sicien and burial-transit		resulting in death) Last	Que to (or as a consec	quence of):					
8760	The law requires thet the death certificate be executed as has been signed by the attending physicien and rage 2 should be detached for use as the burial-transit	Physician/Medical		d. your						
9	ng ph as ti	Jed	IF FEMALE:						10	
Box	eath certific attending p	25	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	ancy al death 3 [⊒Ectopic pregnancy	y		23d. Date of deli	very Day Year
	dea of fo	SCI	in the past 12 months?	4□Pregnant at time of o	death 5	Other (specify)			World	ouy rour
P.0	that the de ned by the a detached t	ř.	9 □ Unknown					an Diller		the course of death?
	res the igned be del	b	Part II. Other significant cond	litions contributing to death but not re-	sulting in the t	ınderiying cause giv	en in Part I.		acco use contribute to	
Records,	w require been sign	e e	1 Wysthas	na -				1 1 4 65	s 2□No 3□Pr	obably 4 Tuberown
ပ္ထ	law ras be	pie		/				24a. Was an autopsy		topsy findings available completion of cause of
Ř	The la	Completed	V					perform 1 ☐ Yes 2	ed? death? DNo 1 ☐ Yes	2□ No
of Vital	iclan: Th certificete rector, pag	Be	25. Was case referred to examiner?	cal			26. Place of Dea	th (Check only one)	
<u>_</u>	Physician: r this certific ral director.	2	1 ☐ Yes 2 🐼 💜 0	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Ott	ner. 4 Mirsing H	ome 5 Resider	nce 6 □Other (Spec	cify)
	ding Ph h. After thi funeral		27. Manne Death 1 Vatural 5 ☐ Pen	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	ry at rk?	28d. Describe how	w injury occurred	
Division	Attending or death.	Certification:	2 Accident inve	estigation			Yes 2 □No			
Ξ	r Att	Ħ		ald not be armined 2 e. Place of Injury - At houlding, etc. (Special contents)	nome, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ıral Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page									
	d hou t hou une une	edical	(Check only 2 Medic	fying Physician: To the best of my kn cal Examiner: On the basis of examin						
	To the Hospitel within 24 hours of To the Funerel completely filled	Med	one)	and manner stated.	7	29c. Licens	se number	nı.	d. Date signed (Monti	h Day Year)
	5 ¥ 5 Po	Σ	29b. Signature and title of cert	Panont	111	10 290. Licens	1764	10 1	1 2 m	7
			MO	my peres	7 1	ソリケ	1 1011	[]	1010	/ '
	2		30. Name and address of pers	on who completed cause of death (Ite	m (3a) (1700	Print) A	212- 1	20 VViin	00 MD2	1201
			31. Date filad (Month, Day, Ye	7 ULOW SILLU (ar) 32. Registrar's Sign	Pature 0	me	21-13			, ,
	St Regist	ate rar	31. Date filad (Month) Day, Ye	2007 Age 32. Hegistral's Sign						

07-00114 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Patricia Louise Lamartina State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 5, 2007 Year Medical Examiner 0124 hrs Louise Patricia Lamartina 4a Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Months Days Hours Director 220-86-2073 Country) MD 32 JUN 29, 1974 Usual Residence of Decedent È 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Anne Arundel MD Glen Burnie 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 256 Heartwood Ct 21061 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Specify White of Health and Mental Hygiene If item 27 is marked other than "natural", ģ 15 Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 12 Administrative Airport 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Grady traumatic event, Patricia Yutzy 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD William Grady/Father 5820 Hunt Club Rd Elkridge, MD 21075 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc Donation 5 Other Specify 1/8/07 Baltimore, MD 'n 21. Signature of Funeral Service Licensee C. Todd Dring 22 Name and Address of Facility Cremation Society of Maryland, Inc. Frederick Rd Baltimore. MD 21228 23a Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Immediate Cause (Final disease Hanging Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED g physician a AMENDED #23a,27,28a-f, perMe g863, 1/17/07 TT Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 ✓ Yes 25 Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Natural 5 Pending 1 Yes 2 No FNd 1/5/2007 subject hanged self 2 unknown Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Director: d in by the f within 2 To the I To the

28f. Location (Street and Number or Rural Route Number, City or Town, State) 256. Heartwood Ct. Clen Burnie, MD 28e Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be determined (Specify) Home Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 50K 29c. License number 29d Date signed (Month, Day, Year) Dend WS O.C.M.E. January 5, 2007 n who completed cause of death (Item 23a) ress of pers 111 Penn Street, Baltimore, MD 21201

Laron Locke MD Assistant Medical Examiner

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	Certific	ate of D	eath	, , , ,	Reg. No	-00	
Physiciar Medical Examin		1. Decedent's Name (First, Middle,Last) Cynthia L. Linds	2 y	- · · · -		Mon	of Death oth Day uary 5, 2007	Year	3 Time of Death 2 3
		4a. Facility Name (if not institution, give street and numb Northwest Regional Hospital	er)		City, Town, or Location of andallstown	Death		County of Deat	
Funeral Director		5 Social Security Number 6 Sex 7. 216-72-8863 6 Sex 7.	Age (In yrs. last birt	_	Under 1 Year If Under Months Days Hours	Min.	te of Birth(MM/	Forei	rthplace (State or gn Maryland
any	F	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d Inside City Limits
*	<u>.</u>	Maryland Baltimore	Pikesv						1 Yes 2 X No
oith the Maryland 23a or 28a-f shov notified at once.	I Director	10e Street and Number 614 Cliveden Road		16	f. Zip Code 21208			States	of America
er death w	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Deced Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Year		If Yes,	ecedent of Hispanic Origin specify Cuban, Mexican, I s 2X No specify:		etc.)	14. Race - Amer White, etc.	rican Indian, Black,
ours aft	g P	15. Decedent's Education (Specify only highest grade of		Decedent's I	Isual Occupation (Give king working life. DO NOT u		ne 16b. K	and of Business	/Industry
11215-0036 Id be filed within 72 hours afthen Hygiene Tarked other than "natural" event, the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	Secret		se retired)		•	t of Justice Prisons
21215-0036 Juld be filed within 7 IMental Hygiene marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)		000100	18.Mother's		Middle, Maiden		1110010
ID 2121; should be fil and Mental F 7 is marked natic event,	To Be	Thomas Barton Schanberge 19a Informant's Name/Relationship (Type, Print)		b. Mailing Ac	dress (Street and Numb	raine :		tv or Town, State	e, Zip Code)
nore, MD 2 ggs 1 and 2 shou tt of Health and N t: If item 27 is n other traumatic			Spouse) 6	14 Cli	veden Road,	Pikes	ville, l	Maryland	1 21208
Ore, ges I an t of Hea : If ite		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from	State cremat	tory or other	'	Date			Town, State 21207
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr	1	4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee	Lorra		rk Cemetery				Maryland
		About Lemma 23 Part I. Enter the disease, or complications that cause	2	8728	L Liberty Ro	oring l ad. Rai	Byers Fo ndallsta	uneral I own. Mai	Directors,Inc
Physician /Medical	1	failure. List only one cause on each line			node of dying, such as car	diac or respira	atory arrest, sho	ck, or heart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Ti		sm					Death
No. II	ان	Sequentially list conditions, if any, leading to immediate b. Deep Venous Due to (or as a co							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
recuted and transit		events resulting in death) Last Due to (or as a co	risequerice or).						
be exessician a	/Medical	UNPENDED X AMENDED	28a,b,c,d,f	f,perME,	g863, 1/17/07	TT			
38760, rdffcate be ming physici as the buril		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, out 1 Live birth	come of pregnancy		eath 3 Ectopic		i i	Date of deliver Month	y Day Year
Box 68 e death certifing the attending ed for use as t	sicial	1 Yes 2 No 9 V Unknown 9 Unknown			(Specify)				
that the d	Phy S	Part II. Other significant conditions contributing to de		ig in the unde	rlying cause given in Part	23	e. Did tobacco i	use contribute to	the cause of death?
S, P.C uires that n signed I	ed b	Obesity, Hypertension	<u>-</u> -			_			babiy 4 Unknown
cords, law requit	Completed by					24	a. Was an autopsy performed?		utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page		25 Was case referred to medical			26 Place of Death (C		Yes 2 No		es 2 No
Vita hysician this cer	ğ	examiner?	atient 2 🗸 ER/O	utpatient 3	Othos	Nursing Home		nce 6 Othe	r.
Division of Vital Records, P.O tal or Attending Physician: The law requires that the after death "a Director: After this certificate has been signed by the funeral director, page 2 should be detended by the funeral frector, page 2 should be detended by the funeral frector, page 2 should be detended by the funeral frector, page 2 should be detended by the funeral frector, page 2 should be detended by the funeral frector, page 2 should be detended by the funeral frector frequency fr		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of (Month, Death of Investigation) 12/1/2	y,Year) Unk	Time of Injur newn 00 am	28c. Injury at Work?	Subje	escribe how inju ct fell down	ry occurred stairs and in	jured knee
Division al or Attend s after death the Director: ed in by the f	Certification	3 Suicide 6 Could not be			ctory, office building, etc.	28f. Lo	cation (Street at Town, State)	20 Ist St	reet, Number, City
l file bou	Medical Ce	29a Certifier (Check only one) 2 Medical Examiner: On the basis of e	my knowledge, de	ath occurred				d manner as stat	
To To con	Mec	and manner state 29b. Signature and title of certifier	ed		29c License number		29d. E	ate signed (Mo	onth, Day, Year)
		Carol Haller			O.C.M.E.		Janı	ary 6, 2007	
6		30 Name and address of person who completed cause of Carol Allan, MD Assistant Medical Ex	, ,	Penn Stre	et, Baltimore, MD 2	21201			
Sta Registra		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	desu	20				
registi	۳.	JULY A COOL TOOK	Marion No.	3 30					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TYPE 5 per FH G863 1.710/07 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Tanuan 6.00A.M. Gail Ardella Moats 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Washington Med Ctr Burnie Anne Arundel Glen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 🖺 F Hours Yrs Director 68 12/15/1938 WV Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Items 23a 8551 Neptune Drive 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 'natural", or 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 is marked other th any Injury or other traumatic event, the once. Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Timothy Crites Stella Crites 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Moats/Husband 8551 Neptune Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem Pk 01/08/07 Marriottsville, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician omter /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 the ! as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) s after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide in by t Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mp. s of person who completed cause of death (Item 23a) (Type, Print) anokn

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

09

ORIGINAL

Hospital or Attending Physician: 24 hours after death. within 24 hor To the Fune completely f the

filled in by

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D4141@

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month Day, Year) 0

MARYLAND 21204 OSLER DRIVE, TOWSON, 7601 JOGINDER_P. M. D. MEHTA.

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

er

29a. Certifier

(Check only one)

Medical

32. Registrar's Signature

and manner stated.

mehla

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per th 9863 1-12-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year **Physician** Kathleen Miller Murphy January 4, 6:25 р м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Edenwald Towson Baltimore 8. Date of the (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 926 Maryland Days Hours Min. Months 220-22-1881 1 □ M 2 🙀 F 80 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 4017 Briar Point Road 21220 U.S.A. Funeral 'natural', or items dical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White þ 3X Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Funeral College (1-4or 5+) Elementary/Secondary (0-12) John C. Miller, Inc. President/Funeral Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John С. Miller Frieda Mueller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Murphy, III-son 4017 Briar Point Rd., Middle River, MD Health em 27 i 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Immanuel Lutheran 1/8/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. M 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine sician and solutions burial-transit Due to (or as a consequence of) physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 25. Be Certification: To this After t 27

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, nours after death.

neral Director: Ailled in by the fu 24 hours a within 2

Baltimore, Maryland 21215-0036

			1 ☐ Yes 2 No	3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed? 1 Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home	e 5□Residence 6□C	Other (Specify)
27. Manna of Death 1 Natural 5 □ Pending 2 □ Accident investigation		Work?	d. Describe how injury occ	urred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office 28	of. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ar ation, in my opinion, death occurred	id due to the cause(s) and d at the time, date and place	manner as stated. e, and due to the cause(s)
29b. Signature and title of certifler		29c. License number	29d. Date sig	ned (Month, Day, Year)
MA	m physician	D2976	9 1/	8/07
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	-1	. //	1 2/2/28
inrelino	D. Albrerne a	n 516W. K	olling Pol	Bulo und
31. Date filed (Month, Day, Year) JAN 0 9	32. Ségistrar's Signature			•

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death January 6, 2007 **Physician** Timothy Maitland Mosner 2:20₽ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 220-62-1390 53 Director July 24, 1953 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" --- any injury or other traumatic everal. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD Carroll Sykesville 1 ☐ Yes 2 DNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 7 Bethway Dr. Apt. 202 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Culpan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specifwhite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Len Stoler Car Salesman N/A 17. Father's Name (First, Middle, Last)
William Mosner 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Sheckells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bill Mosner- Brother 129 Orthoridge Rd. Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Evans Funeral Chapel/Belair 9/07 Forest Hill, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation 21. Signatore of neral Service Licenses Center 2325 York Rd. Timonium, MD 21093 111 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Physician NAG Cancer /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No s after death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Division or Vital Records,

I Mothy

State Registrar Charies no 6701 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 09

Carles ST Atolline MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Closta Mae Myers JANUARY 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Y April 6, 9. Birthplace (State or Foreign Year) 919 Taylorrs ville, North Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 87 Months Hours 219-28-1319 1 M 2 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Monkton Baltimore 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 16901 York Rd. USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drumcliff Clerk Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Osborne 17. Father's Name (First, Middle, Last) Be Bill Deal ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16901 York Rd. Monkton, MD 21111 Glenn H. Myers, Jr.- Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney (Valley Memorial Gardens 1 VBurial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 1/11/2007 4 Donation 5 ☐ Other (Specify) 21. Signatur of Fulleral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Center 2325 York Rd. Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TYPE I AORTIC DISSECTION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown tate has been signed by page 2 should be detact The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 **X**inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 28a. Date of Injury 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ILIA CEBALLOS, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Regiétrar's Signature 31. Date filed (Month, Day, Year)

D 25886

9 JAN 0

			For State State Registrar	of Maryland		irtment of H tificate of L			ene g. No. 200	7 00253
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic	_	William Henry Miller S	r.				January	7, 2007	11:55 P ^M
,	Examin	er	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Death		4c. County of Dea	
- sto	نبد نبدن - بدد		Gilchrist Hospice 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimor	TE inthplace (State or Foreign
	Funeral		1 1 M 2□F		Yrs.	Months Days	Hours Min.	(Month, Day, 05/02/1	Year) C	Country)
	Director		216-24-6312 Usual Residence of Decedent	76				05/02/1	930 198	ryland
	yland now at		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f st	ţ	Maryland N/A	Balt	timore	9				1 XYes 2 No
	hours after death with the Maryland tura!", or Items 23a or 28a-f show al Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	23a ust b		2629 Dulany Street			21223			United St	
	tems	Funeral	Armed	ecedent Ever in U.S. Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
20	s afte	by F	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Year of	es 2 No Give r Dates:		I□Yes 2 X No	Specify:		Specify:	No. 3 to a
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Menth Hygiene. It of Health and Menther Hygiene. If item 27 is marked to ther than "natural", or Items 23a or 28a-f show or other traumatic evem, the Medical Examiner must be notified at		15. Decedent's Education		16a. Deced	ient's Usual Occupa	ation	1 1	16b. Kind of Busines	hite s/Industry
Ċ	in 72 " nat	Completed	(Specify only highest grade complete	ed) e (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	during most of work f)	king		
7	I within jiene. r than " the Med	E	Elementary/Secondary (0-12) Colleg	9 (1-4015+)	Truck	Driver			Grocery	
2	othe rent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ө (First, Middle, M	faiden Surname)	
<u>a</u>	Aenta Aenta rked rlc ev	고	Jacob Miller				Emma Sec	ebold		
e S	2 should be and Mental is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	ig Address (Street a	and Number or Ru	ral Route Number,	City or Town, State,	, Zip Code)
Σ	and 2 n 27 l		<u> Helen M. Dugas - Daught</u>			Jessica :			Maryland	
o e	ages 1 ent of He t: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	om State cen	ce of Dispo netery, crer	sition (Name of natory or other plac	ce)	Date 2	20c. Location - City of	or Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 M Other (Specify) Fit on C	ment Ceda		Ll Cemete		1/2007 B	Baltimore,	Maryland
Baltimore,	permit. Pag Department important: I any Injury c		21. Signature of Funeral Service Licensee	1 050	i i	Name and Addres		aral Homo	oc D A	
_	₽0 = # O		9 achier a. Web	N CFOP	55	11 Edmon	dson Aver	nue Balti	more, Mar	yland 21229
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	^	Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Stroke				\ .	1-1	Days
10 30-	/Medical Examiner		Due	to (or as a conseque	4	h -	,	œ/ -	or i	
		_	Sequentially list conditions, b.	to (or as a condeque	prillat	in	70	100	\mathcal{J}	gears
ix	ted rsit	Examiner	cause. Enter Underlying Cause (Disease or injury	12 (21 0.0 0.0 0.0 100 400			Sol 1	Molla	b.,	
1	xecur and al-trar	xar	that initiated events	to (or as a conseque	ence of):		-\4\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 /0/10	1	
68760,	icate be executed physician and s the burial-transit		d					Mr.		
89	ificate g phy as the	edical						51		
Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physician/M		outcome pf pregnand		Ectopic pregnancy	1 / No		23d. Date of d	
 D	deatle atte	icia	In the past 12 months?	egnant at time of dea		Other (specify)	100		Month	Day Year
о. О	at the by th tache	hys	9 🗆 Unknown				/			
Ś	es tha	by F	Part II. Other significant conditions contributing		ting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ğ	equir en si ould I	ted	Fall with Suldwal h					1 L Ye	es 2 No 3	Probably 4 Unknown
Vital Records,	law r as be	Completed	Spontaneous Subdural	hematom	<u></u>			24a. Was ar autops	v prior to	autopsy findings available o completion of cause of
<u>~</u>		Con						perform 1□ Yes 2	ned? death′ No 1⊟Ye	? es 2□No
lita	clan: ertific	Be (25. Was case referred to medical examiner?			low		th (Check only one	в)	+
	this ald	10				nt 3□DOA Oth	4 Li Nursing H		nce 6 Other (Sp	pecify) Hospile
D D	ding F	ion:	1 □ Natural 5 □ Pending	ate of Injury Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2.⊠No		ow injury occurred on Step Stee!	f
S	Attend death. sctor: /	cat	3 Suicide 6 Could not be 290 ₽	ace of injury - At hom	UNENN no farm str	" (163 27410			Rural Route Number,
Division or	i or Atten after death Director: I in by the	Certification:	4 ☐ Homicide determined jb	uilding, etc. (Specify)	10, 10,111, 01	204,1401077, 011100		City or Town	Lany Sheet	0
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier Certifying Physician: To		ledge, deat	h occurred at the tir	me, date and place			
	e Ho: 124 h e Fur letely	edical	(Check only 2 Medical Examiner: On the							
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens		29	9d. Date signed (Mo	nth, Day, Year)
			>allane a	S		D59	3303	_	Janvary	8 2007
,	12		30. Name and address of person who completed of the complete o		23a) (Type	Print)	S/ BA	Turis 6	Janvary 1	4
	Sta		31. Date filed (Month, Day, Year) 3	2 Registrar's Signatu	ıre		150			1
	Regist	ar	IAN 0 9 2007 A	100 10	Rose	and b				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma		artment of F		nd Mental Hy	giene2 (007	00251
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medi		Anne Malone	9				Jan	3 Day 2	o ŏ°7	11:20p M
1	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of	Death	4c. Coun	ty of Death	
			7336 Chesapeal	ce Road		Mi	ddle	River	Bal	timo	re
	Funeral		Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year		4 Hrs. 8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		215-03-5182 ¹	M 2 🔀	93 Yrs.	Months Days	Hours	Min. (Month, Da	, 1913	Cou	yland
	p ,		Usual Residence of Decedent								•
	anylar ahow	1_	10a. State 10b. County		10c. City, Town or Lo		D !				10d. Inside City Limits
	e Mg	양	MD Baltin	iore		Middle 1	River				1 ☐ Yes 2X No
	or 2	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23a		7336 Chesape	ake Roa	đ	212	20		USA		
	ems erms	Funerai	11. Marital Status 1	Was Decedent E Armed Forces?		Was Decedent of H	ispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)		ice - Americ	
9	or it	Y.	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	0	I □ Yes ¾ □ No	Specify:	deno moan, etc.)		ack, White,	
ğ	urai	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:		20.00	opecny.		Speci	^{⊮y:} Whi	te
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Modical Examinar must be nutitied at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa kind of work done of	durina most o	of working	16b. Kind of I	Business/In	dustry
2	of thin	ш	Elementary/Secondary (0-12)	College (1-4or 5+	life I	DO NOT use retired	1)		Reta	4 1	
	led v lygie her t		8th		Jai	C 5					
2	B in P	Be	17. Father's Name (First, Middle, Last)	Coollon				s Name (First, Middle,		тө)	
<u>\{ \}</u>	should ind Men marke umatic	٦	Constantine					garet Koh			
Maryland		9	19a. Informant's Name/Relationship (Typ					or Rural Route Numbe			
	and ealth n 27 ner tr		Anthony Goeller	/broth	i con	Sandhi	LL Ro	ad Balti	more	MD 2	1221
Baltimore,	40 O I		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re	movalfrom State	20b. Place of Dispo-	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	own, State
Ĕ	permit. Pages, Department of I Important: If its any injury or o		4 Donation 5 Other (Specify)	movarirom state	cemetery, crem	n Cemet	ery 1	/6/07]	Baltim	ore	MD
a	porting y injured	1	21. Si mature of Fundral Service License		1 1 22	Name and Addres	s of Facility	300 Mace	7770	Dalt	- 100
מ	8 0 E 8 8		Cour len	amel	h. c	onnellv	Fune	ral Home	Ave.	Balt	O. MD
			23a. Parti. Enter the disease, or complice shock, or heart failure. List only one	ations that caused t	he death. Do not ente	er the mode of dying	g, such as ca	rdiac or respiratory ari	est,	sex	Approximate
	Physician		Immediate Cause (Final								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	ANAL	consequence of):	VOMA					
	Examiner			240 10 (0. 43 4	consequence ory.						
		6	Sequentially list conditions, larry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of).						
4	uted d ansit	듵	cause. Enter Underlying Cause (Disease or injury								
` -	be executed icien and burial-transi	Examiner	resulting in death) Last	Due to (or as a	consequence of):					-	
Q/20	icate be executed physicien and s the burial-transit	dicai									
	ficate physics ts the l	ğ	a.							10.4	
XOX	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of	pregnancy						
ă	atter	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at til	Fetal death 3	Ectopic pregnancy Other (specify)				ite of delive onth	ny Day Year
j	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	mo or death 3 🗆	Ottlei (specify)					
7	that ed by deta		Part II. Other significant conditions contr	ibuting to death but	not resulting in the un	deriving cause give	n in Part I	23e Did tol	22000 1100 000	tributa to th	e cause of death?
records,	sign d be	₽		MENTI		sonying outdoo givo					
ğ	need thoul	Completed		,,, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	/				es 2□No	3 Proba	ably 4 Nunknown
ฏ	has has e 2 s	dr.						24a. Was a autops	n 24b.	Were autop	sy findings available inpletion of cause of
=	cate pag	ខ្ល						perform 1 ☐ Yes	ned?	death?	2□ No
	cian	Be	25. Was case referred to medical examiner?				26. Place of	Death Check only on	е/		
5	hysi his c	ို	10103 2000	spital: 1		3□ DOA Othe	r. 4 🗆 Nursir	ng Home 5 Reside	nce 6 Oth	er (Specify)
=	of the state of th	<u>e</u>	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occur	red	
NISIOII NISIOII	eath.	Certification:	2 Accident investigation		·		es. 2 No				
2	iract iract		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	· At home, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Numb	er or Rural	Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elder death. within 24 hours elder death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as										
	toep t hou unel	cai	29a. Certifier Certifying Physic	ien: To the best of	my knowledge, death	occurred at the time	e, date and p	lace, and due to the ca	use(s) and ma	inner as sta	ited.
	the F in 24 the F iplets	Medicai	one)	and manner state		sugation, in my opi	mion, death d	occurred at the time, da	ate and place.	and due to	the cause(s)
	To To T	2	29b. Signature and title of certifier			29c. License			9d. Date signe		Pey, Year)
/	1		Jasmin Ho	ine	M.D	Do	2614	180	1/4	10	7
1)	b/ \\ 1		30. Name and address of person who com	pleted cause of dea	th (Item 23a) (Type, P	rint)	01	180	1	10,	
V	/ Y\		Jasmin Hans	4920 (Campbell 1	3/vol, 1	BALtim	ine Min	2122	4	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature			1 100	~13	Ø	
	Registra	r	1881 A B 000	202	2.	9-					

ORIGINAL

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

0

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department 3, Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1205 A M Quinn P Mc Cleer 07 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltimore Mary 10
If Under 1 Year If Under 24 Hrs. Maryland University of Maryland Medical Systems 8. Date of Birth (Month, Day, Year)

Dec. 29,1981 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F Months Days Hours Director 484 02 5041 Iowa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 775 West Pratt Street, Apt. B 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced white white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic event". College (1-4or 5+) Elementary/Secondary (0-12) Engineer Northrop Gruman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Wood McCleery Teresa Rozenboom Orton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa R. Orton - Mother 8717 Timberland Drive Wake Forest, NC 27587 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Jan. 8, 07 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Epstein Barr vival infection /Medical ue to (or as a consequence of): Examiner eukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of: physician and s the burial-trans Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached it 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably <u>aastrointestinal</u> Nimorrhage 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1∏ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD AV4176435521678 01/07/07

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, MD 2120

South Greene Street,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

Stoddard

JAN 0 9 2007

Tiffany 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007^{Year} Bertha May Mentzel 2:00 A.M January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Baltimore Towson Brighton Gardens 6451 N. Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 28, 1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M **XX**F 213-12-7771 Sept. 86 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h Counts XXYes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4117 Buena Vista Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 ☐ Yes 200No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Dinges Leanna White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Frank Mentzel Son 1401 Medfield Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 01/09/2007 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ur / Funeral Service Licenses Page - Name and Address of Facility Burgee - Henss - Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an perform 2.2 No 1□ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

and

physician

this

After t or Attending

within 24 hours a To the Funeral L

completely

Medical

Physician

/Medical

Director

Funeral

ģ

Completed

Be

ဂ္

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Mexical

Examiner Physician/Medical þ Completed Be (Certification: To s after dec. ral Director: After filled in by

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

IF FEMALE: 23b. Was decedent pregnant 25. Was case referred to medical examiner? 1 ☐ Yes 2 🕦 No

1 Natural

2 Accident

4 🗌 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

27. Manner of Death 5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) ASSISTED IN LIGHT 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1/Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier

29c, License number

5 State

Registrar

AARON J. CURREN WO GTOIN. Charles ST BAGAMERE AND 21204 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Spell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day 7:55 PM Robert James McAuley, Jr. January 6, 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1422 Gunston Court Harford Bel Air If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1**∑** M 2□ F 135-36-7793 Mar. 24, 1945 New Jersey Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21015 1422 Gunston Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6+ Pharmacist U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Beatrice Trerotola Robert James McAuley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne Mae McAuley / Wife 1422 Gunston Court, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Arlington Nat'lCem. 1 2**-**8-07 Arlington, Virginia 21. Sig ut ra di Juneral Servica Lidensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months nal Cancer disease or condition resulting in death) Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

worle

ir than "natural", or iteme 23a or 28e-f ehov the Madical Examinar must be nutified at

Director

Funeral

þ

Completed

Be

္ပ

Examiner

Physician/Medicai

þ

Completed

Be

70

Certification;

Medical

1 ☐ Yes 2 🙀 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of contifier

death with the Maryland

filed within 72 hours after

Hygiene.

nit. Pages 1 and 2 should be filed vartment of Health and Mental Hygic ortent: if item 27 is marked other or other traumatic event,

permit.
Departr
Importe

Baltimore, Maryland 21215-0036

be executed attending physicien for use as the buria signed by

nours after death.

nerel Director: After this certific
filled in by the funeral director, within 24 hours a To the Funerel C

Division of Vital Records, P.O. Box 68760,

State Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2007

Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway,

401 North Wells Messessmith M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

JAN 0 9 2087

5 Pending

investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day Year)

Thomas Joseph Mackenney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** 1335 hrs January 3, 2007 THOMAS JOSEPH MACKENNEY 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5900 block of Northwood Drive Baltimore N/A 5. Social Security Number Funeral If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Director Months Hours Min oreign 16-08-9 M Country) 21 8,1985 JUNE md. Usual Residence of Decedent Ob County 10c. City, Town or Location 10d Inside City Limits N/A BALTIMORE 28a-f show MD. 1X Yes 2 or items 23a or 28a-f showmust be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 CURLEY ST. 21213 Ν. USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. Yes 2X No BLACK Widowed Divorced If Yes, Give Year traumatic event, the Medical Examiner Yes 2 XNo specify. Specify "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene is marked other than MD 21215-0036 UNEMPLOYED N/A12TH 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) THOMAS L. MACKENNEY TRACEY JONES Be 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code JOSEPH L. MACKENNEY /grandfather) 1214 N. CURLEY ST. BALTO, MD. 21213 es 1 and 2 of Health 20b. Place of Disposition (Name of cemetery. 20a Method of Disposition Baltimore, 20c Location - City or Town, State JAN.10,2007 ARUNDEL CO. crematory or other place) 1 X Burial 2 Cremation MT.CALVARY CEM important: Dopation 5 Other Specify MD. ture of Funeral Service Licensee 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME \mathbf{E} BALTO, MD PRESTON ST Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Asphyxia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical UNPENDED X AMENDED sician #1,perME, g863,1/19/07 TT Division of Vital Records, P.O. Box 68760, attending physi for use as the bu 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ Yes 2 V No 3 Probably 4 Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Fo the Hospital or Attending Physician: Be examiner? Hospital: Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 V Yes After 27. Manner of Death 28a Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted Natural FOUND Pending death Yes 2 V No within 24 hours after death To the Funeral Director: Jan 3 2007 1335 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Lown, State) 5900 block of Northwood Drive, Baltimore, MD (Specify) Woods 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 4, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) gistrar's Signatu State IAN 0 9 Registra

		1- For Amend #5,10a, perFH, G803, 1/9/6	and / Depa <i>Cer</i>	rtment of H	ealth and Mental Death	Hygier Reg. 1	2007	00260
	3 ₁₁	Decedent's Name (First, Middle, Last)			2. Date Mont	of Death	Nav. Vass	3. Time of Death
Physi /Med	ician dical	Henry Moran				4N	Pay Year 2007	10:55pm ^M
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	4	4c. County of Death	
		27001 Righy hat Rd		EASTO			TALBO	<i>)</i>
Funera Directo		120-22-8010 1 2 F	rs. last birthday) 3 Yrs.	ff Under 1 Year Months Days	Hours Min. 8. Date (Mon	th, Pay, Yea	ur) Cour	place (State or Foreign ntry)
and		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation			1	Od. Inside City Limits
Aarylan febow	ō	MD						¥Yes 2 □ No
the t	Director	10e. Street and Number	aston	10f. Zip Code		10a. (Citizen of What Cour	ntry?
3 with	0	27001 Rigbylot Road		21601			S.A.	,
death	Funeral	11. Marital Status 12. Was Decedent Ever in		Vas Decedent of Hi	spanic Origin? (Specify Yes	or No-	14. Race - Americ	
nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours atter death with the Maryland at of Heath and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow or other treumatic event, the Medical Examinations to an action at	Ď	1 Never Married 2 Married 1 Never Married 2 Married 1 Wes 2 No 1 Yes 2 No 1 Yes 3 Vidowed 4 X Divorced Year or Dates:		Yes 2 XNo	n, Mexican, Puerto Rican, et Specify:	c.)	Specify: Wh:	etc. ite
5-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usuaf Occupa	ition uring most of working	16b.	Kind of Business/Ind	dustry
12 if in 12	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired,				
22 yale v		Master Degr	ee Safe	ety Engin			overnment	
be fi	Be	17. Father's Name (First, Middle, Last) Frank Moran			18. Mother's Name (First, M	fiddle, Maidi	en Sumame)	
V Sould	2				Helen Lucy			
Mai 12 st h and 7 is n treum		19a. fnformant's Name/Relationship (Type, Print)			nd Number or Rural Route /			
Healt		Tim Moran, son 20a. Method of Disposition	Z/UUI D. Place of Dispos		Road, Easton		y Land 216 Location - City or To	601
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: if item		1 Burial 2 Cremation 3 Removal from State	cemetery, crem	atory or other place	e)		•	
Iting it. P. Itant		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Metro Cr	ematory	01-05-0	7 Bal	timore, Ma	iryland
Baltimore, Mispermit. Pages 1 and 2 Department of Health a important: if item 27 in any injury or other tre	S C C C C C C C C C C C C C C C C C C C	21 Systems of the State of the		TO The same and Address	s of FacilityCharles	S. Ze:	iler & Son	
		23a. Pa 11 eter e issaase, or complications that caused the de			rn Ave., Balt		, MD 2122	Approximate
		shock or heart failure a ist only one cause on each line. Immedia Cause (Final	0	, ,	, ,	,		Interval Between Onset and Death
Physicial /Medica		disease or condition resulting in death) a. Due to (or as a cons		cu				3 YRS.
Examine	er	Due to (or as a cons	requerice or).					
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	equence of):					
outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
O, exec en an rial-tr	Exa	resulting in death) Last Due to (or as a cons	equence of):					
icate be executed physicien and the burial-transit	dicai	d						
r 68 ortifica ing pt	Med	fF FEMALE:						
P.O. BOX 6 that the death certific ed by the attending p	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 mogths?		Ectopic pregnancy			23d. Date of delive Month	
o designation of the article of the	Sici	1 Yes 2 No 9 Unknown 9 Unknown	of death 5	Other (specify)			WORLD	Day Year
P.C	F.	Part II. Other significant conditions contributing to death but not r	reculting in the un	darking saves av	a in Boot I 22a	Did tabass	use contribute to the	an anuse of death?
JS, ires ti	þ	Atrial Fibrillation	esuiting in the un	idenying cause give	nin Parti. 236.	1 Yes	_	4
require hould	eted	HITE TOTTING				1 162	2 140 3 1 1 100	abiy 4 @ONKHOWN
Secondary Belaw	Jg.				24a.	Was an autopsy	prior to cor	psy findings available mpletion of cause of
al F	S				10	performed? Yes 2 2		2□ No
Division of Vital Records, P.O. for Attending Physician: The law requires that the dather death. Director: After this certificate hes been signed by the finest the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Be	25. Was case referred to medical examiner?		. 3□ DOA Othe	26. Place of Death Check	/		
Phys of ral di	5	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpatient 2 27. Manner of Death	ER/Outpatient	JU DOA	4 Indising none 3		6 ☐Other (Specif) fury occurred	0
ding After	ē	1 ☐ Naturaf 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury Work	? 'es 2 \ No	31.00 11044 111	jury occurred	
Attendii death. ctor: A	fica	3 Suicide 6 Could not be 28e Place of Injury - At	t home, farm, stre			tion (Street	and Number or Rura	I Route Number.
Div alter Direction	Certification:	4 Homicide determined building, etc. (Spe	ecify)		City	or Town, Sta	ate)	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certitic within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely tilled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death ination and/or inv	occurred at the tim estigation, in my op	e, date and place, and due t inion, death occurred at the	o the cause time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
To the within 2 To the complet	₹	29b. Signature and title of certifier		29c. License	number - MD.	29d. C	ate signed (Month,	Day, Year)
F > F 0		1 0.10 - 11.11 M N		DAA	40274		1/5/20	107
~		30. Name and address of person who completed cause of death (It	tem 23a) (Type F		700.1		. ,	
101		I. Allen Webb, AD 8570	1	nerce Dr	1. Supe 100	EAS	TON M	D 21601
15 m	state	31. Date filed (Month, Day, Year) 32. Registrar's Sig						
Regis	strar	IAN n 9 2nd7	M	Rosello D				
DHMH 17 Rev 1	1/2001	Sittle O Cool	do for	A COLUMN TO SERVICE STATE OF THE PARTY OF TH				
			ORIGIN	AL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY Pay 7, 2007 **Physician** 6:45 PM Nace Agnes /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 8. Date of Birth (Month, Day, Year) March 14, 1929 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 💢 F Maryland 77 216-24-5469 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 **Y**No Directo Baltimore Kingsville Maryland 10e. Street and Number 10g. Citizen of What Country? 21087 USA 12509 Belair Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc filed within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Zicha Joseph Vojek ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Belair Road, Kingsville, Maryland 21087 Husband Robert Nace 20b. Place of Disposition (Name of cemetery, crematory or other place) January 20c. Location - City or Town, State 20a. Method of Disposition 1 Mag Bunial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 12,2007 Dundalk, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the last arease or injury Due to (or as a consequence of) Examine and K or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Be Completed by Physician/Medical the attending p for use as use as IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a Division or Vital Records, P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1∐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Heloy M.D. 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND 21204 7601 ABDALLAH J. 31. Date filed (Month, Day, Year) State JAN 09 2007 Registrar

Clifton C. Nicholas Ol. Q2007 11:05a ACCURRENT C. CRY, Town or Location or Death TOWSON Stella Naris Hospice Scalla (Naris Hospice) Scalla (N	Physici	an	1. Decedent's Name (First, Middle, Last)	C.		Nichol	ag	1	Date of Dea Month	Day	Year		e of Death
Stella Maris Hospice Scolar County Newton Program of Maris Hospice (Stellar Land County) London Headers on Concessor (Maris Hospice) London Headers on Co	/Medic	cal							ŊΤ				USA
Second Security Number Second Security Number Second Security Security Second Security Number Second Security Security Second Security Second Security Security Second Second Security Second Second Security Second Security Second Security Second Security Second Security Second Security Second Security Second Second Security Second Second Security Second Second Security Second Second Security Second	Examir	er						aur					
Usual Residence of December 100, Eastern of	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I				rs. 8. [Date of Birt Month, Da	h /, Year)	9. Birt	untrv)	
100. Clark and Number 100. Clark and Number 100. Entered City Lift (1) Short and Number 100. Sho	irector		225-12-4670	83	Yrs.			03	10	23		V	Α
23a. Part I. Enfersive disease, or complications that between constitution as cardiac or respiratory arrest. 23a. Part I. Enfersive disease, or complications that between constitution and cardiac contributions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complications that between constitutions are constitutions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complications that between constitutions are constitutions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complications that between constitutions are constitutions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complications that between constitutions are constitutions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complications that between constitutions are constitutions as a consequence of constitution and cardiac constitutions. 25a. Part I. Enfersive disease, or complication that between constitutions are constitutions and cardiac constitutions are constitutions. 25a. Part I. Enfersive disease, or complication that between constitutions and cardiac constitutions. 25a. Part I. Enfersive disease, or complication that between constitutions and cardiac constitutions. 25a. Part I. Enfersive disease, or complication that the death of cardiac constitutions and cardiac constitutions. 25a. Due to (or as a consequence of): 25b. Was decedent pregnant. 25c. Little part II. Due to (or as a consequence of): 25c. Little part II. Other significant conditions, contributions that between constitutions and constitutions. 25c. Little part II. Other significant conditions contributions that the death of cardiac constitutions. 25c. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Little part III. Littl	at w			10c. City	, Town or Lo	cation						10d. Insid	le City Lim
23a. Part. Enfersive disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Section 1 and 1	a-fsh iffed	향	MD NA	Ва	ltimo	re						1 🔀	Yes 2□
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	or 28 e not	Dire											
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	s 23a nust k	eral	1 10	adaat Coorin III	5 10.1			/C= = =:6:	Van av Na				n
23a. Part I. Enferance disease, or complications that between third all Between Shock, or heart failure. List only one cause on Sach line. 23a. Part I. Enferance disease, or complications that between Shock, or heart failure. List only one cause on Sach line. 25a. Part I. Enferance disease, or complications that between Shock, or heart failure. List only one cause on Sach line. 25a. Part I. Enferance disease, or complications that between Shock, or heart failure. List only one cause on Sach line. 25a. Part I. Enferance disease, or complications that between Shock, or heart failure. List only one cause on Sach line. 25a. Part I. Enferance disease, or complications that between Shock, or heart failure. List only one cause on Sach line. 25a. Each Shock and the Shock of Sach Shock or heart failure. List only one cause on Sach line. 25a. Each Shock decadent pregnant. In the past 12 months? 25b. Was decadent pregnant. In the past 12 months? 25b. Was decadent pregnant. In the past 12 months? 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25c. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to (or as a consequence of): 25d. Up to	item:	Fun-	Armed Fo	rces?	1			(Specify erto Rica	n, etc.)	14		e, etc.	
23a. Part I. Enfartifie disease, or complications that influence i	al", or Exam	5	3 ☐ Widowed 4 ☐ Divorced If Yes, Gi	ve ates:		∐Yes 2 ⊠ No	Specify:			S	pecify:	Blac	k
23a. Part. Enfersive disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Section 1 and 1	natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occup	oation during most of v	vorking		16b. Kind	of Business	/Industry	
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	han " e Mec	ď	Elementary/Secondary (0-12) College (1-4or 5+)			_			Crow	n Cor	·k &	Seal
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	ther t				1.14	uck Dr.	1	lame (Fir	st, Middle,				
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	ked o	o B					Mattie	e Cr	ump		,		
23a. Part Enfert #e disease, or complications that followed here and Deady shock, or heart failure. List only one cause on Sach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, indiraral Beween Proceedings and Deady Script of the part o	s mar	-											_
23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inthivial Between Cheek and Death Indianal Indiana Contribution of Cheek and Death Indiana Contribution (Part Indiana) 23a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indianal Indiana Contribution (Part Indiana) 25a. Part I. Enfarting disease, or complications that project the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Indiana Contribution (Part Indiana) 25a. Enter the death of the death	n 27 i ner tra		•		1		ary Sti		, Ba				
23a. Part Enfert de disease, or complications that between the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the part of the cause of the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the part of the cause of the mode of dying, such as cardiac or respiratory arrest, medical cause (Final disease or conditions) and the part of the cause of the disease or conditions and the part of the pa	If iter or oth			State G	emetery, cren arrason	Forest pia	ce)		_	20c. Loca Owines	tion - City or 	Town, Stat	_
23a. Part. Enfersive disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Section 1 and 1	rtant; njury		4 ☐ Donation 5 ☐ Other (Specify)	Gre	wnsvi	110 Vo	. [1/]	12/0	7	Crow	nevil	.le,	Md
23a. Part. Enfersive disease, or complications that between third all services of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 25a. Part. Enfersive disease, or complications that between third all services of shock, or heart failure. List only one cause on such line. 25a. Part. Enfersive disease, or complications that between third all services of shock, or heart failure. List only one cause on such line. 25a. Part. Enfersive disease, or complications that between third all services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches all services of such line. 25a. Part. Enfersive disease, or complications that between third all services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches all services of such line. 25a. Part. Enfersive disease, or complications that between third all services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches all services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and services and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and services and services and services and services and services and services and services and services and services and services and services and services and services and services and services and services and services and servic	lmpo any l		21. Signature of Furnese Service Licensee	Jan.	Ma A	rch Fyl	fowest ash Ave	e, B	alti	more	, Md	212	15
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)	10		23a. Part1. Ener ne disease, or complications that	used the death								Approx	imate
Due to (or as a consequence of): Due to (or as a consequence of):	eician		Immediate Cause (Final									Onset	and Death
Sequentially list conditions, it any leading to immediate cause. Enter Underlying that inflated events resulting in death) Last To put to (or as a consequence of):			resulting in death)			ACCIDENT							
Due to (or as a consequence of): The property of the proper	miner		Sequentially list conditions b.										
Due to (or as a consequence of): The past 12 months? 23d. Date of delivery 23d. Date of deliver	##	iner	if any, leading to immediate cause. Enter Underlying	(or as a consequ	uence of):								
To page of the second of the	and Il-tran	хаш	that initiated events resulting in death) Last Due to	(or as a consequ	uence of):								
24a. Was an autopsy performed? 1 Yes 2 No 3 Hobality * April 24b. Were autopsy findings available property to completion of cause death? 1 Yes 2 No 3 Hobality * April 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 25. Was case referred to medical examiner? 1 Yes 2 No	sician			,	,								
24a. Was an autopsy findings available to be autopsy findings available to autopsy findings available to autopsy findings available to autopsy findings available to autopsy findings available to autopsy findings available autopsy findings available to autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy findings available autopsy find	g pnys as the		d										
24a. Was an autopsy findings available of the completion of cause death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 3 DOA 28a. Date of Injury 28b. Time of Injury Month, Day Year 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only only 29a. Certifier (Check only only 29b. Time of building, etc. (Specify)	endin r use	M/us	23b. Was decedent pregnant 23c. If yes, ou			lEctopic pregnanc	v			23			.,
24a. Was an autopsy findings availably performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 3 DOA 28a. Date of Injury Dinjury	d for	sicis	1 Preg	nant at time of de							Month	Day	Year
24a. Was an autopsy findings available to completion of cause death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury Month, Day Year) 28b. Time of Injury Month, Day Year) 28c. Injury at Work? 1 Natural 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only 29a. Certifier (Check only Month, Day Year) 29a. Certifier 29a. Certifier (Check only Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Ψ Φ	문		eath but not recu	ulting in the u	aderlying cause giv	ven in Part I		23a Did to	phacco use	contribute t	n the cause	of death?
24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings avail prior to completion of cause death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 3 DOA 28. Date of Injury 3 Suicide 4 Homicide 4 Homicide 28. Place of injury - At home, farm, street, factory, office 28. Place of injury - At home, farm, street, factory, office 29a. Certifier (Check only 29a	d by the letache	b	Tartin Still Significant Solidations contributing to S	cuit but not rest	atting at the di	identying dadde gi	ron in r art i.						
autopsy performed? prior to completion of cause death? performed? signed by the d be detached									an	24h Were a			
25. Was case referred to medical examiner? 1	been s should	leted						-	auto; perfo	rmed?	prior to death?	completion	of cause of
Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC	been s should	ompleted			E								
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Be. Date of Injury 4 Homicide 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Date injury - At home, farm, street, factory, office 2 Be. Date injury - At home, farm, street, factory, office 2 Be. Date injury - At home, farm, street, factory, office 2 Be. Location (Street and Number or Rural Route Number, City or Town, State) 2 Be. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Describe how injury occurred 3 Could not be determined 4 Could not be determined 4 Could not be determined 5 Could not be d	been s should						26. Place of D	Death (Ct	neck only d	ne)			
2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	been s should	Be	examiner?	Inpatient 2 □	ER/Outpatien	t 3□ DOA Oti	ner.				Other (Spe	cify) H (OSPIC
28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Place of injury - At home, farm, street, factory, office 28g. Certifier (Check only one) 28g. Place of injury - At home, farm, street, factory, office 28g. Certifier (Check only one) 28g. Place of injury - At home, farm, street, factory, office 28g. Certifier (Check only one) 28g. Place of injury - At home, farm, street, factory, office 28g. Certifier (Check only one) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State)	should	To Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ 27. Manner of Death 28a. Date	of Injury	28b. Time of	1 SULPOA	ner: 4 🗆 Nursin	g Home	5 ☐ Resid	dence 6		ecify) H (OSPIC
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Special Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	should	To Be	examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 5 Pending investigation investigation	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ner: 4□ Nursin ry at rk?	g Home 28d.	5 ☐ Resid Describe I	dence 6	occurred		
(Check only one) (Check only	should	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place	of Injury th, Day Year) of injury - At ho	28b. Time of Injury	28c. Inju Wo M 1	ner: 4□ Nursin ry at rk?	28d.	5 ☐ Reside I	dence 6)	occurred		
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	should	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Could not be determined 28a. Date (Mor investigation) 4 Set Could not be determined	of Injury hth, Day Year) e of injury - At ho ling, etc. (Specify	28b. Time of Injury	28c. Inju Wo 1	ner: 4 □ Nursin ry at rk?] Yes 2 □ No	28d.	5 ☐ Reside In Describe In Des	dence 6) now injury of Street and in vn, State)	occurred Number or R	ural Route	
D43725 1/4/07	Funeral Director: After this certificate has been s sely filled in by the funeral director, page 2 should	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date (Mor investigation) 6 Could not be determined 28e. Place build 29a. Certiffer (Check only (Check only 12) Medical Examiner: On the build	of Injury nth, Day Year) e of injury - At ho ling, etc. (Specify be best of my kno- basis of examina	28b. Time of Injury	28c. Inju Wo M 1 ==	ner: 4 Nursing ry at rk? Yes 2 No	g Home 28d. 28f. ace, and	5 Residue Residue Rescribe I	dence 6) now injury of the following street and in the fol	Number or R	ural Route	Number,
	Funeral Director: Atter this certificate has been s rely filled in by the funeral director, page 2 should	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date (Mor investigation) 6 Could not be determined 28e. Place build 29a. Certifier (Check only one) 1 Certifying Physician: To the cone)	of Injury nth, Day Year) e of injury - At ho ling, etc. (Specify be best of my kno- basis of examina	28b. Time of Injury	28c. Inju Wo M 1 = 28c. Inju Wo	ner: 4 Nursing ry at rk? 1 Yes 2 No ime, date and pl opinion, death o	g Home 28d. 28f. ace, and	5 Residue Residue Rescribe I	dence 6) now injury of the following street and in the following street and in the following street and properties.	Number or R nd manner a lace, and du	ural Route s stated. e to the cau	Number, use(s)

DHMH 17 Rev 1/2001

JANUARY 4, 2007

CHARLES NICHOLAS

Registrar

State

POTEE

BACTIMORE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JAN. VINCENT L. NARDONE, SR. 1,2007 10:38 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Year)

FEB. 23,1921 BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2□F Yrs. 218-01-6685 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3400 HARMONY COURT 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes **②** No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No <u>Ş</u> 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN BREWERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F LEONARD NARDONE ANTOINETTE GIAMPETRO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTOINETTE CASEY/ DAUGHTER 3921 FOSTER AVENUE, BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF JESUS 1/5/07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1700 S. CONKLING STREET, BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Brain CANCER Immediate Cause (Final disease or condition resulting in death) **Physician** weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Artery disease, Bladder Concer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation or Attending 1 Natural Injury 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 3☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the

State

31. Date filed (Month, Day, Registrar

30. Name and address of person who completed cause

6701 GBM C 32. Registrar's Signature

of death (Item 23a) (Type, Print)

N. Charle St. Balto. Md

29d. Date signed (Month, Day, Year)

0

Baltimore, Maryland 21215-0036

Box

P.0.

Division or Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician / Month Dav 1.LIVER 0036 A M ANVARY 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Specialty University NI 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**№** 2 ☐ F Months Days 218.22.7092 Director MD 2.05. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Defamit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits MD Baltimore 1 **⊠**/es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 Ailsa Avenue 21214 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Be Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) timore, Maryland 2121 Elementary/Secondary (0-12) 12+h qrade Social Securit Coilege (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Maurice C. Oldham Gladyp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R Val Route Number, City or Town, State, Zip Code) Dorothy B. Oldham 20a. Method of Disposition 2305 Aiba Avenue Baltimore MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01.10.07 Owingo Milb, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Lughn C. greene Funeral Senice 1
105 York Road Baltimore MD 21212 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebro vasene men disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending p for use as IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by icate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes spital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 / Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred After 1/Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier Prelita MI) D34974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CHARUMEHTAMD 681 South Charles Street, Baltimero, MD 21230

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 0 9

22 Stram,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•		1- For State Registrar Certificate of Death	Reg No	200	7 0026
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) 2. Date Mont	of Death th Day uary 2, 200		3 Time of Death 2310 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		c. County of Death	
	ļ	Dorsey Road & W B & A Road Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date 1 Peach 1 P		Anne Arundel	
Funeral Director		1124 60 2062	/4/19	76 Poreig	thplace (State or in N Y
id how any ce.		10a State 10b. County 10c City, Town or Location MD Howard Columbia			10d Inside City Limits 1 Yes 2 X No
21215-0036 Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 21044	10g Cit	izen of What Cour	
death with r items 23:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Ye Armed Forces? 1 Yes 2 X No	es or No- etc.)	14 Race - Ameri White, etc.	
ural", o	ক্র	3 Wildowed 4 Divorced if Yes, Give Year 1 Yes 2 X No specify	0 1466	Specify: Whi	
15-0036 Gled within 72 hours a Hygiene. 4 of yelloner than "natural of other than "in Medical Examin".	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Digital Press Operato		Kind of Business/li Printi	
5-00 led with Hygien other					-
21215-0036 Juld be filed within 7 Important Hygiene in marked other than in event, the Medica	e B				
MD id 2 shoulth and in 27 is aumatic		Ms. Patricia Laverne 805 Encampment Ct. My			
Baltimore, MD 2121 remit Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumantic event.		1 Burial 2 K Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory 1/8/07	,	Balto	. M.D
Baltimo permit Page Department of Important: injury or oth	C	A Fignature of Funeyar Service Licensee 22. Name and Address of Facility Slack 3871 Old Columbia P	Funer	al Home	. P.A.
Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat failure. List only one cause on each line.	tory arrest, sho		Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			- Deau
	Jiner L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
uted nd ransit	Examiner				
O, e be executed /sician and burial - transit	Medical	UNPENDED AMENDED			
× 68760, h certificate be tending physici use as the bur	/sician/M		230	Date of delivery Month D	ay Y ear
Box 68 he death certify the attending hed for use as	EL	3 OTHER WIT			
ires that the classifier by the datached	≥	1			ne cause of death? ably 4 Unknown
cords,	ompleted		Was an autopsy performed?		opsy findings available ompletion of cause of
tal Rec	၂ -	25 Was case referred to medical 26 Place of Death (Check only one)	Yes 2 N		2 No
Vital Physician:	90	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home		nce 6 🗸 Other	Scene
Division of Vital Records, tal or Attending Physician: The law requirer as after death al Director: After this certificate has been sing the funeral director, page 2 should be treed.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a Date of Injury 28b. Time of Injury 2306 hrs 28b. Time of Injury 2306 hrs 1 Yes 2 No 28d Dec Driver of Death 2306 hrs	scribe how inju of auto in c	ollision with p	ick up
Divis pital or At ours after d cral Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Loca or Tr	own. State)	nd Number or Rura A Road, Glen B	al Route Number, City urnie, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	١٣	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e cause(s) and e, date and pla	d manner as stated ce, and due to the	d. cause(s)
F×Fö	Me	29b Signature and title of certifier 29c License number		Date signed (Mont	h, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	Jant	uary 3, 2007	
10		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
Sta Registra		31. Date filed (Month, Day Year) 9 200 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ozie Lee Perry 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Washington County Hospital Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 □ XF 261-64-0104 79 Director 29,1927 Jan. Georgia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Mydical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1041 B Noland Drive Funeral 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook 6 Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Will Virgin ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Mollie J. Prince 1041 B Noland Dr., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wildwood Cemetery 1/13/07 Bartow, Florida 21. Signature of Funeral Service Licen 22. Name and Address of Facility Alexander Funeral Home 620 Avenue T N.E., Winter Haven, Florida 33881 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final txtee **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 1 ☐ Yes 2 Z No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 2100 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ 1 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation neral Director: A 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at to the Funeral Completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

(16trm

32. Registrar's Signature

			1 - State o	Maryland / Dep <i>Ce</i>	ertificate of Dea		Hygiene (07 00268
	Physic		1. Decedent's Name (First, Middle, Last)	RUTH	Paulel	2. Date Mont	of Death	Year 2°29 M
	/Medi- Examir Funeral Director		4a. Facility Name (If not institution) give street and num Mainor Care Nursing F 5. Social Security Number 6. Sex 577 - 40-4516	nber) DINE 7. Age (In yrs. last birthday, Yrs.		ntion of Death	of Birth	
	he Maryland 8a-f show offilied at	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND BALTIMORE	10c. City, Town or L	TOWS	50N		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-1 show entry injury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Dir	Armed For 1 Never Married 2 Married 1 Yes If Yes. Giv	2 2No	Was Decedent of Hispani If Yes, specify Cuban, Me		or No- c.) 10g. Citizen of C 14. Rac Bla Specif	15A, De - American Indian, ck, White, etc.
21215-0036	led within 72 hour: yglene. her then "naturel" it, the Medical Ex	Completed	3 ▼Widowed 4 □ Divorced Year or Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	16a. Dece (Give life.	dent's Usual Occupation a kind of work done during DO NOT use retired)	GUARD	16b. Kind of B	USLACK usiness/Industry THORE CITY
Maryland	ould be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last) PURCELL	Ross	5	Nother's Name (First, M 9NN/E	SUE	SUMLER
	ges 1 and 2 sh I of Health and If item 27 Is m or other traum		19a. Informant's Name/Relationship (Type, Print) ADDIE ELLIOTT (DAU 20a. Method of Disposition 1. Spurial 2 □ Cremation 3 □ Removal from 8	GHTER) 2 20b. Place of Disponentery, cre-	ing Address (Street and No MORN G osition (Name of matory or other place)	STAR CT.	BALTO. 20c. Location	State, Zip Code) MD 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Baltimore,	permit. Page Department Important: eny injury once.		21. Signature of Funeral Service Licensee	ZION COMI	MUNITY CEMETA 2. Name nd Address of F OSEPH H- B	rown, Jr. F	· Fulton An	ventie MO21217
8760,	Medical Medical fransit in bourial transit	dicai Examiner	resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	or as a consequence of): abella or as a consequence of): abella or as a consequence of):	ter the mode of dying, such	In find	ory arrest,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medic	in the past 12 months?	int at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Dai	te of delivery nth Day Year
	w requires that i been signed by should be deta		Part II. Other significant conditions contributing to de	ath but not resulting in the u	indertying cause given in P		Did tobacco use cont	ribute to the cause of death? 3 □ Probably 4 □Unknown
of Vital Records,		Completed by	<i>b</i>			1 D Y	autopsy performed? (es 2 No 1	Were autopsy findings available prior to completion of cause of death?
Division of Vit	Ing Physic After this ce uneral direc	ation: To Be	27. Manner of Death 1 ∰Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	patient 2 ER/Outpatier Injury , Day Year) 28b. Time of Injury	nt 3 DOA Other:			
Divis	2 3 2 6	Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, str g, etc. <i>(Specify)</i>	reet, factory, office	28f. Locati City o	ion (Street and Numb ir Town, State)	er or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the 2 Medicel Exeminer: On the ba and mann	sis of examination and/or in	vestigation, in my opinion,	death occurred at the t	ime, date and place, a	and due to the cause(s)
)	7 × 10		29b. Signature and title of cartifier	mp	29c. License numb	464	1/8	(Month, Day, Year)
	7		30. Name and address of person who completed cause SHOAII3 A HASHANI M	1), 821 N	Print) . EMTANS	I Smte 3	of BALT	Imoremo sizol
	Sta Registr		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#31 per DVR, C863, 1/9/07, WS
State of Maryland 7 Department of Health and Mental Hygiene state Registrar Amend #7 Per FH g863 1/10/07 Centificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 0900 HRS Raymond Popp 2007 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2 Summitt Hill Ct. Apt. A-4 Catonsville Baltimore GATORSVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Dec. | 10, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 82 1 XM 2 ☐ F Mary Land Yrs. 216-03-5171 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2 Summitt Hill Ct. Apt. 4 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Carrier Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evonce. Charles H. Popp Ella Regina Hoffman မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Popp, wife 2 Summitt Hill Ct. A-4 Catonsville, MD. 21228 20b. Place of Disposition (Name of complete, crematory or other place)

MD Veteran s Cemetery 01-07-07 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville UI-U/-U/
22. Name and Address of Facility
Ambrose Funeral Home, Inc. Crownsville, MD 21. Signature of Funeral Service Licensee ekus 1328 Sulphur Spring Rd. A Arbutus, Mn. 21227
Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse uence of): **Examiner** ordna Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 1 De Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00051872 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (rossroads # 56 Cettonsville, MD 21228 MD 10 brial olling Eveit 2E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Dimitri Polydefkis Jan. 3, 2007 3:39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10 East Lee Street Apt. 1007 Baltimore

Funder 1 Year | If Under 24 Hrs. n/a Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Days 1**≱**M 2□F Months Hours 79 Director 047-30-3337 23, 1927 Greece Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 East Lee Street Apt. 1007 21202 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ Specify. 3 Widowed 4 Divorced white white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Polydefkis မ Maria Kyriakides 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Polydefkis - Wife 10 East Lee Street Apt. 1007 Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Jan. 4, 07 Baltimore, MD 21. Signature Funeral Service Licenses ²², Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lancey /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 9 □ Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2/2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 【 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 PResidence 6 □Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 5 Pending investigation Injury neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29d. Date signed (Month, Day, Year) DIRECTOR, Loukour MEDICAL ONCOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, 20 Boltruone, MID ROSSC, DONEHOWER, MID Johns Hophans Hospi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2007 Registrar

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of I			Reg. No.	00271			
П	Physici	an	Decedent's Name (First, Middle, Lass	t)				2. Date of De Month	ath Day Year	3. Time of Death			
	/Media		Queen Ester	Puryear				January	6 200	7 0156 AM			
	Examir	ıer	4a. Facility Name (If not institution, give				or Location of Deat	,	4c. County of Dea	ath			
			Union Memorial 5. Social Security Number 6. So		(In yrs. last birthday	Balt If Under 1 Year	imore If Under 24 Hrs	8. Date of Bird	N.	Thplace (State or Foreign ountry)			
	Funeral Director			M 2XIF	Ven	Months Days	Hours Min.	(Month, Da					
			Usual Residence of Decedent		65 IIs.			10 27	7 1941	VA			
	yłanc		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
	Marie -	ctor	MD N/A		Baltim	ore				1 Yes 2 No			
	or 28	Sire.	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	72 hours after death with the Maryland natural', or itema 23a or 28a-f ehow dical Exaction from the notified at	Funeral Director	612 Bartlett Av	renue		21:	218		USA				
	r deg	nue	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	- 14. Race - Am Black, Wh				
36	s afte , or fi	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 N If Yes, Give	0	1 ☐ Yes 2 🗓 No			Specify:				
Ö	tural'	D D	37 Widowed 4 □ Divorced	Year or Dates:	150 Doo	identia Haval Ossa				Black			
21215-0036	be filed within 72 hours after death with the Marylan stat Hygiene. od other then "naturel", or Itema 23a or 28a-f ehow other then "naturel", or Itema 23a or 28a-f ehow event, the Medical Examplear matte be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	dent's Usual Occu kind of work done DO NOT use retire	pation during most of woi ed)	rking	16b. Kind of Busines:	vindustry			
12	within ene. then "	E	Elementary/Secondary (0-12)	College (1-4or 5-	Chim		/						
D	Hygir other	BeC	17. Father's Name (First, Middle, Last)	N/A		es	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)				
Maryland	should be nd Mental marked o	To B	Wyatt	Good	de			Pauline	9	Harris			
ary	SEL		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address (Street	t and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)			
	C = 64 F		Cynthia Goode-dau	ghter	612	Bartlett	t Avenue	Baltimor	e, MD 21	218			
ore	T of		20a. Method of Disposition 1 □Burial 2 □Cremation 3 □	Pamoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - City o	Town, State			
Ĕ	Page neutral n		4 Donation 5 Other (Specify		Greenmo	unt Crema	atory 1/1	2/2007	Baltimore	MD			
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	see		2. Name and Addre	ess of Facility M	ARCH FUN	IERAL HOME-	EAST			
	20 = 6 0		Dlady	more, MD	21202								
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused tone cause on each line	the death. Do not er e.	ter the mode of dyi	ng, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Cardio myopathy Due to (or as a consequence of):										
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of:	8				Hour			
н		_	Sequentially list conditions,	b. Hyper	tensio,	V			-				
V	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01,000	de la consequencia de la consequ								
7	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):								
8760,	e be executed rsiclan and e burial-transit	icai	l	d									
9	tificete ng phys as the	edi											
Вох	eath certifi ettending for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		∃Ectopic pregnanc			23d. Date of de	livery			
	death	sicie	in the past 12 months? 1 ☐ Yes 2 No	4☐ Pregnant at t		Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year			
P.O	at the de d by the o	Physician/Med	9 Unknown										
	The law requires that the death certificete be executed ate has been signed by the ettending physiclan and page 2 should be deteched for use as the burial-transit	<u>۾</u>	Part II. Dther significant conditions co	ontributing to death but	t not resulting in the i	inderlying cause gr	ven in Part I.		obacco use contribute t	o the cause of death?			
Vital Records,	v requir been s should	Completed						101	res 201No 3□P				
3ec	e law has t	Ig I						24a. Was autop	osy prior to	utopsy findings available completion of cause of			
a	an: The l tificate he tor, page							1 Yes	20 No 1 ☐ Ye	2 □ No			
₹	Ser Ser	o Be	25. Was case referred to medical examiner?	Hospital:		V Ott	300	th (Check only o					
ō	Phys or this oral di	-	27. Manner of Death	28a. Date of Injury (Month, Day	t 2 ER/Outpatie	nt SIA DOA	4 Nursing H		dence 6 Other (Spe	ocify)			
o	Attending I r death. ector: After by the funer	텵	1 Natural 5 Pending 2 Accident investigation		Year) Injury		rk?]Yes 2 ∐No		. ,				
Division	ii or Attendi atter death. I Director: A d in by the fu	HC	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm, si	reet, factory, office		28f. Location (S	Street and Number or R	ural Route Number,			
ā	s after or Dire	Certification	4 Hottledo	building, etc.	. (Зресну)			City or Tou	wi, State)				
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by ti	Medical	29a. Certifier (Check only one) (Check only one)	iner: On the basis of a and manner state	examination and/or in ed.	ivestigation, in my o	opinion, death occu	rred at the time,	cause(s) and manner a date and place, and du	to the cause(s)			
	To the within 2 To the complet	ž	29b. Signature and title of certifier	Atten	dine	29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)			
	1		4. 500 M	D phos	ician	D	60581	3	TANUARU	6 2007			
	h		30. Name and address of person who	ompleted cause of the	ath (Item 23a) (Type	Print) Ba	It more	, MD 2	1218				
			HELENA YOU, A 31. Date filed (Month, Day, Year)	10 UNTO	n hemorr	d Hospitz	il 201	East U	niversity f	arkway			
	Sta Registr		JAN 0 9 201	32. Registrar	is Signature	3			JANUARY 1218	~			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician Month 2301 /Medical 4a. Facility Name (If not institution, give street and n 4c. County of Death 4b. City, Town, or Location of Death Examiner OAK CREST CARE CENTER PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 10/22/1924 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X Director 219-18-4943 82 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD BALTIMORE PARKVILLE Director 1 ☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 WALTHER BLVD. #334 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify þ 3 XWidowed 4 ☐ Divorced Specify: WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12TH GRADE OWN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I JOHN MOAN **EMMA** KEENAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health as Important: If item 27 is any injury or other trau WILLIAM C. POMPLON/SON 4607 VICKY ROAD BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) PARKWOOD CEMETERY 1/8/2007 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD arr1. Enter the disease, or comply ations that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to him det cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Lua to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 2 🗆 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

law requires that the death certificate be executed Division or Vital Records, P.O. certificate this or Attending within 24 hours a To the Funeral I Hospital To the

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and attle of certifier



icense nimber

29d. Date signed (Month, Day, Year)

	•	State of Maryland / Department of Health and Merchant Registrar 1 - State Registrar Certificate of Death	-	2007 00273
PKysicia: /Medica		11 WYPA TUMPHEY	2. Date of Death Month Da	3 2007 1:12PM
Examine Funeral	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Author Author	8. Date of Birth (Month, Day, Year) Jan. 15, 192	Death 9. Birthplace (State or Foreign Country)
Director 28a-f show multiped at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Jan.15,192	1 MD 10d. Inside City Limits 1 □ Yes 3√□ No
3a or 28a-	ii Direct	10e. Street and Number 10f. Zip Code 21225		lizen of What Country?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28e-1 show other traumatic event. Ite Mudical Examiner must be indiffied at	d by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No I□ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ad within 72 hours all glene. or then "naturel", or the Mydical Experi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) R 16a. Decedent's Usual Occupation (Give kind of work done during most of worker life. DO NOT use ratired) Industrial	ng	ind of Business/Industry ndustrial
Maryland 2121 d 2 should be filed withir th and Mental Hygiene. The marked other than traumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last)	(First, Middle, Maider	
re, Mary s 1 and 2 sho f Health and P item 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Mrs. Betty Master / Daughter 71 Martinique Circle I 20a. Method of Disposition	Berlin MD 2	
Baltimore, permit. Pages 1a Depertment of Hee Important: if item any injury or othe once.		1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Specific Dises 22. Name and Address of Facility Sing 1 Second Avenue SW	gleton Fune	en Burnie, MD eral Home, P.A.
76(licai Examiner	d	, exasca	Approximate Interval Between Onset and Death 2 days
I Records, P.O. Box 68 The law requires thet the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
Records, P.	leted by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available
	a	25. Was case referred to medical 26. Place of Death	autopsy performed? 1 Yes 2 1000	prior to completion of cause of death?
	ition: To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 28d. Describe how inju	
To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
the Hospi iin 24 hou the Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge death occurred of the time, date and office, a construction of the course of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date and	d place, and due to the cause(s)
To the vithin 2 To the comple	~	DR Flannery no (5641) RESOOD	Jar	wary 3, a00
5 Stat	0	30. Name and address of person who completed see of death (Item 1997) (Type Print) The Lee-Arre Markey Mo Havby Havby Havby 1997 31. Date filed (Month, Day, Year) 32. Registrar's signature	5.300/ F	tanover street
Registra		M. M. M. M. M. M. M. M. M. M. M. M. M. M		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 007 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month David Rix Jan. 2007 5, 10:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X**M 2□F Months 73 213–30–0621 March 27,1933 Va Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2622 Liberty Parkway 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Self Employed</u> Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leon Rix Emily Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Price-Rix <u>2622 Liberty Parkway Dundalk Md.</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan 6, 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore 2007 Signature of Fineral Service Licens 22. Name and Address of Facility Connelly Funeral Home of Dundalk 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, land, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC ARREST disease or condition resulting in death) Due to (or as a consequence of): Arrhythmia ARTERY Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2₹No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notlfied at

ms 23a or 2

"natural", or items

the Medical

al Hygiene.

ath and Mental Hygi 27 Is marked other r traumatic event, t

item 27 I

permit. Pages 1 Department of H Important: If ite any injury or ot

1 and 2 should be fill Health and Mental H

Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

the

filled in by

within 24 hours aft

To the Funeral D

completely filled in To the Hospital

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-trar the SS use ed by the a signed to 2 should has page certificate this

funeral director. After after death.

Division or Vital Records, P.O.

Physician:

or Attending

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 Could not be determined

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 XNatural

2 Accident

4 Homicide

3 ☐ Suicide

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MZU MD 29c. License number D012185

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doctor Tagi MD. 4940 Eastern Avenue, Baltimore, Maryland

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) JAN 0 9 2007



			1 - For State Registrar	State o	of Marylan		artment of tificate of		nd Mental Hy	giene Reg. No.	2007	00275				
П	Physic	ian	Decedent's Name (First, Midd)	e, Last)		61	. –		2. Date of Do Month	eath Day	Year	3. Time of Death				
	/Medi	cal	Elizabeth			Rober			Januari	1 7	F005					
4	Examir	ner	4a. Facility Name (If not institution	-		_		or Location of		4c.	County of Death					
	Funeral		Johns Hookins 5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Yea			dh	O Rieth	place (State or Foreign				
	Director		225-30-0394	1□ M 2 汉 F	8		Months Day		Min. 8. Date of Bi (Month, Di June 1	192	5 Vire	place (State or Foreign Intry) Jinia				
	D .		Usuat Residence of Decedent							1						
	ehov	5	10a. State 10b. County	•	10c. City	y, Town or Lo						10d. Inside City Limits				
	the Marylar 28s-f ehow	Director	Maryland Balt:	imore		Dunda						1 ☐ Yes 2 🙀 No				
	with Se or		7114 Martell Ave	enne			10f. Zip Code	, 222			zen of What Cou SA	ntry?				
	death me 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. \			in? (Specify Yes or No		14. Race - Ameri	can Indian				
9	after or Ite	Ē	1 Never Married 2 Marr		2 No		_		in? (Specify Yes or No Puerto Rican, etc.)		Black, White	, etc.				
93	hours after death with the Maryland turel', or tteme 23a or 28a-f show al Examinar must be notified at	d by	3 XWidowed 4 ☐ Divorced	tf Yes, Gi Year or D	ates:		∐Yes 2XX N	o Specity:			Specify:Whit	ce				
21215-0036	nati	Completed		t's Education st grade completed)		16a. Deced (Give	lent's Usual Occi kind of work don OO NOT use retii	upation e during most	of working	16b. Kir	nd of Business/Ir	ndustry				
12	within ene. then	m C	Elementary/Secondary (0-12) 6 years	College (1-4or 5+)		bly Line			Core	ral Moto	nre				
	Hygid other	BeC	17. Father's Name (First, Middle,	Last)		Lassen	OLY DIL	_	's Name (First, Middle							
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehove other traumatic event, the Medical Examinar must be confined as	To B	James Shifflett					Magg	gie Morris							
an	2 sho and h	ľ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Stree	et and Number	or Rural Route Numb	er, City or	Town, State, Zi	Code)				
	and lealth m 27 her tr		Darlene Mc Krush	n daught					e, Dundalk,	Mary.	land 21	1222				
Baltimore	Pages 1 nent of H nnt: If Ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation	3 ☐Removal from	State Co.	lace of Dispo emetery, cren	sition (Name of natory or other pl	Jace) J	anuary 8,	20c. Loc	cation - City or T	own, State				
Ę	it. Partmentiment	Lå	4 Donation 5 Dother (S		Sacr		t of Jesus	_			alk, Mar					
Ba	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 le eny Injury or other tra QDCE.	1	21. Signature of Funeral Service	y Co	nnel				Home Of I		lk,P.A. lk,MD. 2	21222				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	aused the death ach line.	n. Øg not ente	er the mode of dy	ying, such as ca	ardiac or respiratory a	rrest,		Approximate Intervat Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ase or condition although a Sepsis												
	Examiner		,	Due to	Due to (or as a consequence of):											
,		er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	ience of):										
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.												
ó	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		or as a consequ	ence of):										
8760,	ohysica the bu	lica		d												
9 ×	entific fing p	Mec	IF FEMALE:	1						-						
Вох	leath certific attending pl	ian	23b. Was decedent pregnant in the past 12 months?	1□Live b	come of pregnar irth 2 Tetal ant at time of de	death 3	Ectopic pregnanc	су		2:	3d. Date of delive Month	ery Day Year				
o.	The law requires that the death certificate be executed te hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	1 U Yes 2 Mo 9 □ Unknown	9□ Unkno		atn 5	Other (specify)					,				
۳.	that		Part II. Other significant condition	ns contributing to de	eath but not resu	Iting in the un	derlying cause g	iven in Part I.	23e. Did t	obacco us	e contribute to t	ne cause of death?				
Vital Records,	quires no sign uld be	ed by							10,	Yes 2	No 3□ Prot	pably 4 Unknown				
ဝွ	law requir 8s been s 2 should	ompieted							24a. Was		24b. Were auto	psy findings available				
H.	The la	E O								osy rmed? 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of				
/ita	dentifical	BeC	25. Was case referred to medical examiner?				-	26. Place o	of Death / Check only of		10 163	20.140				
of \	Physic this c	ည	1 ☐ Yes 2 ☑ No			R/Outpatient	30 DOA		ing Home 5 Resid			y)				
u C	ding f	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	9	h, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe I	now injury	occurred					
Division	If or Attendiate death. Director: A in by the fu	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	not be 200 Place	of Injury - At hor	me farm etra]Yes 2∏No		Stenat and	Alumbar as D	15				
Ö	To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide determine	buildir	ng, etc. (Specify))	et, factory, office	,	City or Tov	vn, State)	INUTIDE OF HURS	l Route Number,				
	pspite hours unere ly fille	aic	29a. Certifier 1 Certifyin	g Physician: To the	best of my know	vledge, death	occurred at the t	time, date and	place, and due to the	cause(s) a	ind manner as s	ated.				
	the H in 24 the Fi plete	edicai	(Check only 2 Medical f	and manr	isis of examination	on and/or inv	estigation, in my	opinion, death	occurred at the time,	date and p	place, and due to	the cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					se number		29d. Date	signed (Month,	Day, Year)				
•	.1		1420		ical oc	otor	RE	5-00	00	Janu	any 4	7007				
	1)			who completed caus	e of death (ttem :	23a) (Type, F	rint)		Baltimore			1 1 1 2 2 1 1				
	Sta	te	31. Date filed (Month, Day, Year)	ezern 32. B	4940 gistrar's Signatu	tasky	n Ave	nue 1	barmore	_ , M	aryland	21224				
	Registr		JAN 0 9		eur l	4 So	1425				_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4, Jude Rhinehart Ethan lanuar 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor N/A OMS 8. Date of Birth (Morith, Day, Year)

Jan. 3, 201 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Unk . 6. Sex 7. Age (In yrs. **Funeral** 1X M 2□ F Mary land 0 2007 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show ms 23a or 28a-f sho r must be notified a 1 ☐Yes 2 XNo Director Md. Baltimore Reisterstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 12800 21136 Sagamore Forest Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐xNo Specify. Specify: þ 3 Widowed 4 Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gill David Paul Rhinehart Marv Margaret ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 12800 Sagamore Forest Ln. Reisterstown, Md. 21136 Mr. David P. Rhinehart/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any Injury or o once. ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 1/10/07 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final espiratory **Physician** 0 hours disease or condition resulting in death) /Medical to (or as a consequence of Examiner piratoru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed trematurit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical phys the t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ho autopsy performe certificate 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA 2 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after do

To the Funeral Direct
completely filled in by: 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 00056568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

600 North Wolfe Street Baltmone

Mary 12nd

pher Golden

32. Registrar's Signature

William Christo

31. Date filed (Month, Day, Year)

			For State Registrar	State of Mar		artment of I		ind Mer		ene)) 7	00277
	Physicia		1. Decedent's Name (First, Middle, Last, Melvin E.	Rowley					Date of Death	Day Yea 200	3. Time of Death 57 1636 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of	of Death		4c. County of De	
			Union Memorial Hosp	oital			cimore			N/A	1
	Funeral		5. Social Security Number 6. Security Number 147	7.Age MgM 2□F	(In yrs. last birthday	Months Days		Min.	Date of Birth (Month, Day,	Year)	sirthplace (State or Foreign Country)
	Director		216-30-5121 Usual Residence of Decedent		72 Yrs.			1	I <u>-11</u> -19	34 Ma	ryland
	land ow		10a. State 10b. County	1	10c. City, Town or I	ocation					10d. Inside City Limits
	Man	tor	Maryland N/	A	E	altimore					1X Yes 2 No
	or 282	lrec	10e. Street and Number			10f. Zip Code			10	g. Citizen of Whal	
	23a 23a	rai	3026 E. Darby Stree				21211				USA
36	should be filed within 72 hours after death with the Maryland Marked other then "natural", or iteme 23e or 28e-1 ehow marked other then "natural", or iteme 25e or 28e-1 ehow imatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 19	•	. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc. white
21215-0036	hin 72 hou s. nn "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec (Giv life.	edent's Usual Occu e kind of work done DO NOT use retire	during most	t of working		16b. Kind of Busines	ss/Industry
	or the	Соп	8		Prin	ter	1				Sunpaper
pu	tal Hygind other	Be	17. Father's Name (First, Middle, Last)					r's Name <i>(F</i> a Bens		faiden Sumame)	
<u>yla</u>	Men Men Marke Maric	2	Roger Rowley	ma Drinkl	105 145	line Address /Ctros	1			City or Town, State	Zin Cada)
Maryland	d 2 st th and 7 Is n traun		19a. Informani's Name/Relationship (7) Mary Rowley	Wife		E. Darby			more,		s, <i>21</i> p 0000)
Ğ,	Heali Heali tem 2		20a. Method of Disposition	VIII		position (Name of amatory or other pla		Date	-	20c. Location - City	or Town, State
OL.	ages ent of nt: If if		1 2 durial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			11 Cemete	ery	1/8/20	007 G	len Burni	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked eny injury or other traumatic ex anca.		21. Signalure of Funeral Service Licens			22. Name and Addr Burgee-He 3631 Fall	ess of Facility	eitz F	uneral	Home, Ir	ıc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	he death. Do not e	nter the mode of dy	ing, such as	cardiac or re	espiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MUSCO	ardial		arc				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	Examiner	L		b.	consequence of):						
Q	pet list	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (Si as a	consequence cij.						
)′	be executed icien and buriel-transit	xar		c. Due to (or as a	consequence of):						1
,092	ate be executed hysicien and the buriel-transit	cai		d							
68	tificat ng phy as th	P									
Вох	death certifica e ettending ph id for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	□Ectopic pregnan	су			23d. Date of Month	delivery Day Year
О. П	of the deatl by the etter tached for	sici	1 Yes 2 No	4☐Pregnant at ti 9☐ Unknown	me of death 5	Other (specify)				11101101	22,
Q _	thet the		Part II. Other significant conditions co	ninbuting to death but	not resulting in the	underlying cause g	iven in Part I.		23e. Did tob	acco use contribute	to the cause of death?
Division of Vital Records,	8 E 6	d by							1 1 Ye	s 2 No 3	Probably 4 Unknown
CO	w requir s been si should	ompieted							24a. Was ar	n 24b. Were	autopsy findings available
Re	The lavate has	E							autops perform	y prior i ned2∕ death 2. 22 No 1 □ Y	
ital		BeC	25. Was case referred to medical				26. Place	of Death (C	Check only on		
> =	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 👿 No		t 2 ER/Outpati	BILL SE DOA				nce 6 Other (S	pecify)
ū		ë o	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	W			d. Describe ho	w injury occurred	
Sic	Attending r death. ector: Atterby the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	280 Place of Injur	y - At home, farm,]Yes 2□1		Location (St	reet and Number or	Rural Route Number,
ΟĬ	i or Attencated after death	Certification:	4 Homicide determined	building, etc.	(Specify)	street, factory, office	•	25.	City or Town		Transit Tourist Turnion,
	To the Hospital or A within 24 hours after To the Funeral Direction plately filled in b	Medical C		sician: To the best of iner: On the basis of a and manner state	examination and/or						
	ithin it	Med	29b. Signature and title of certifier	und masmer state		29c. Licer	nse number		25	9d. Date signed (Mo	onth, Day, Year)
	8 4 € 4		1 /1 AINH.	Ahr m	Λ	05	4103	•	,	Janian	14. 20107
	00		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Typ	ə, Print)	1100	1.		1 11	11011
	20		Willia	JFV	oh MM	0. 0	un	The	mar	Horpi	of Ball ma
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	r's Signature	2000			(/	(/
	Regist	rar	UNIT U U ZU	UI JEBRUSE	o so fall	ASSES AND ASSESSED AND ASSESSE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 3:26 Mailli Kichards 2007 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore NIA of Maryland Centr Mirrita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 20, 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours 64 181-32-3609 York County, PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No York Haven PA York Director 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 17370 275 River Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Auto Sales and and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator Body Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy J. [Fogle] Richards William A. Richards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 275 River Road, York Haven, PA 17370 item 27 Rebecca L. Richards, wife other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Interpretate If Ite any injury or of once. 1 Burial 2 □ Cremation 3 Removal from State Jan. 4, 2007 Lewisberry, PA Emanuel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 21. Signature of Euneral Service Licensee e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part I. Enter the diseasonck, or heart failure Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** DIDARY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2□ No 1 □Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗹 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 KNatural 5 ☐ Pending investigation in 24 hours and, the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertific)an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Baltmare, MD rud ande Greene Hdan 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Ernest William Ryan 12:34 P™ January 2007 5 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Renaissance Gardens Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 1XM 2□F Months Days Hours 92 217-03-1722 Dec 18, 1914 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 709 Maiden Choice Lane 21228 United States Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grain Elevator Operator Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadie Cook Charles Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Garrett / Son-in-law 727 Muller Road, Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Do 5 Other (Specify) oudon Park Cemetery 1/9/07 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mounde hour Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 No

Physician /Medical Examiner physician and certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at show

"natural", or items 23a or

the Medical

other than Hygiene.

7 is marked other traumatic event,

Department of Health a Important: If Item 27 is any injury or other trau

within 72 hours after

filed

I and 2 should be file and Mental I

Pages 1 ;

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division or Vital Records.

The

Physician:

Director

Funeral

þ

Completed

Be

2

Examiner attending ph for use as t been signed by the sahould be detached this certificate has ral director, page 2:

Physician/Medical þ Completed Be 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certification:

IF FEMALE

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day,

1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

28c. Injury at Work? Injury M 1 Tyes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Mopth, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day Year)

and manner stated.

AHAM -

State Registrar

DriMit 17 Rev 1/200

Medical

JAN 0 9 200



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1021 2007 Harry A. Rau, Jr. anuary 4a. Facility Name (If not institution, give street and n 4h City Tewn or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs. Social Security Number. (In vrs. last b rthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 M M 2 □ F Months Days Hours Min July 20, 1924 212-20-7057 Marvland Usual Residence 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 707 Maiden Choice Lane Apt 8G-14 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 12€ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

1946

Specify.

Industrial oil Sales

18. Mother's Name (First, Middle, Maiden Surname)

(Give kind of work done during most of working life. DO NOT use retired)

Specify

16b. Kind of Business/Industry

White

Oil Company Sales

Baltimore, Maryland

Day

Month

Physician /Medical

Physician

/Medical

Examiner

10a. State

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Funeral Director

Be Completed by

Examiner Examiner

Physician/Medical Completed by Be Certification:

P

Medical

State

30. Name and address of person y

Year)

31. Date filed (Month, Day,

The law requires that the death certificate be executed attending physician and burial-trar Records, P.O. Box 68760 been signed by should be detach Division or Vital Hospital or Attending Physician: After this Director: e Funeral Direc within 2

၉ Harry A. Rau Bertha B. Fields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10709 Faulkner Rdige Circle Columbia, Maryland 21044 Mr. Paul S. Rau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 01/10/d7 orraine Park Cemetery 22. Name and Address of Facility Signature of Funeral Servi Slack Funeral Home, P.A.

Complications that cause 1 the death. Do not enter the mod. 10 d Columbia 12 ke Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the dis-shock, or heart failur Immediate Cause (Final HEARI Atherosc 18Rotic disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (NemiA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Tes 20 No 1 Inpatient 2. ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 4SICIAN

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TR,MO

Registrar DHMH 17 Rev 1/2001 900

South Caton Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4a. Facility Name (If not institution, give street and number) 04-07 1:16 AM 0 1 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Maner Par If Under 24 Hrs. Care Towson 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day Birthplace (State or Foreign Country) **Funeral** Hours Months Days .36.2267 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f ehow treumatic event, the Madical Examiner must be notified at Randallstown Baltimore 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after usen of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced SIACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hetired Military Gavern ment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Atpluant dith trice 19a. Inform nt's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 is any injury or other treuonce. 8046 High Castle Mood Elifoot City MD 91043 ce of Disposition (Name of Date 20c. Location - City or Town, State James Stewart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 30111e O109.2007 Crow sulle MD
22. Name and Address of Facility VOUGHN C. Greene funeral Service * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Vaighne iberty Boad Randallstain MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mainut Severe Physician /Medical Due to (or as a consequence of) Examiner Stromal Gasterointestinal Security 'standing in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 2 No 1 Yes funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) HO054424

Registrar

DHMH 17 Rev 1/2001

State

JAN 0 9 200

Asadi

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O E Imc
32. Registrar's Signature

M Sound

Timonium

rd. Suite #209 1, monium, MD 21093

07-00160

William Paul Louis Siewicki

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2007 00282

		1- For State Registrar		Certifica	ite of D	eath		Re	g. No.	UU/	0028
Physicia ledical Exami			aul	Louis	S	iewicki	2	2. Date of Deat Month January 6,	Day Year		ne of Death 46 hrs
		4a. Facility Name (if not institution, 92906 Dunmurry Road A				city, Town, or Location undalk	of Death		4c. County of Baltimore		
Funeral Director		215–30–8040	Sex 7. Age (I	n yrs. last birth		Under 1 Year If Undonths Days Hou	der 24Hrs. rs Min.		h(MM/DD/YYYY) 21,1932	9 Birthplace Foreign Country)	
ow any		Usual Residence of Decedent 10a State 10b County		c. City, Town o							nside City Limits Yes 2 XNo
Aaryland 28a-f show f at once.	Director	Maryland Balti	liote	Dunc		f Zip Code		110	g Citizen of Wha	L	res 2 ANO
ith the Ma 23a or 28 notified		2906 Dunmurry Ro				21222	_		USA		
15-0036 Iffed within 72 hours after death with the Maryland I Hygiewell Offed offer than "matural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Marri	12. Was Decedent Event Armed Forces? 1 X Yes 2 ed If Yes, Give Year	No No	If Yes, s	cedent of Hispanic Or pecify Cuban, Mexica	n, Puerto R	city Yes or No- ican, etc.)	White,		
ours aft atural"	d by	15. Decedent's Education (Specify	or Dates:		ecedent's L	sual Occupation (Give	e kind of wo		Specify: 16b. Kind of Bus	White siness/Industry	
0036 within 72 ho iene er than "m Medical Es	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		-	f working life. DO NO	T use retire	d)			
5-00% lled within Hygiene	Som	12 years 17. Father's Name (First, Middle, La	2 years		Steel	Worker 18.Mothe	er's Name (F	irst, Middle, N	Bethleh	em Ste	el
2 s at 3 2	Be	John Siewicki				Ame]	lia Sr	nyder S	iewicki		i
AD 2 sho 27 is mati	ဥ	19a Informant's Name/Relationship Rudolph A. Siewi		r 20)54 Su	dress (Street and Nu squehanna	Hall	Road,	Whitefor	d, MD.	21160
Baltimore, N permit. Pages I and Department of Healti Important: If item injury or other trau		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spec		cremato	ry or other p	(Name of cemetery, lace) matory	Janu 9,	ary 2007	20c. Location - 0		
Balt permit. Depart Import injury		21. Sign ture of Funeral Service Lic	enseer (A) 10 ()	lu .	22 Name Conn	and Address of Facili	al Ho	me Of	Dundalk,	P.A.	222
Physician		23a. Part I. Enter the disease, or confailure List only one cause on	nplications that caused the	death. Do not	enter the m	Sollers For ode of dying, such as	cardiac or r	espiratory arre	st, shock, or hear	rt Appr	222 roximate Interval ween Onset and
/Medical Examiner		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease									
j	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b										
	iner	if any, leading to immediate	Due to (or as a consequ	ence of):							
18 14 B	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
ficate be executed g physician and stee burial - transit		UNPENDED	dAMENDED	_							
8760, ifficate be up physical to buri		IF FEMALE: 23b. Was decedent pregnant in the	23c If yes, outcome						23d. Date of d	delivery	
din en	ician	past 12 months?	1 Live birth Pregnant at tim			eath 3 Ectop	ic pregnanc	СУ	Month	Day	Year
U 0 E 70	Physicia	1 Yes 2 No 9 Unkno	9 OTKHOWN								
s, P.O. Boires that the de signed by the	Ş	Part II. Other significant condition	s contributing to death bu	ut not resulting	in the under	lying cause given in P	art I.		2 No 3	_	
ords, w require s been si should b	Completed						_	24a Wasa	n 24b. W	ere autopsy fir	ndings available
eco he law ate has	dwo							autops perform	ned? de	ior to complet⊪ eath? ✓ Yes	on of cause of
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner?				26.Place of Death	(Check on			V 163	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should	۵	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury		tpatient 3	DOA Other 4			Residence 6		
- = ~=	Certification:	1 Natural 5 Pending	(Month, Day, Year)	200.11	inic or injury	1 Yes 2	_	od Describe in	ow injury occurred	u	
Division Hospital or Attendin 24 hours after death Funeral Director: A	tifica	2 Accident Investig 3 Suicide 6 Could n	ot be 28e. Place of Injury	- At home, far	m, street, fa	ctory, office building, e	etc. 28	Sf. Location (So	treet and Number	or Rural Rout	te Number, City
Divi Hospital or 24 hours afte Funeral Dir tely filled in		4 Homicide determine 29a Certifier	1000000								
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examin	ician: To the best of my kr er:On the basis of examin and manner stated			n my opinion, death o	ccurred at the		ind place, and du	e to the cause	
	2	29b. Signature and title of certifier	ela no)		29c. License number O.C.M.E.			January 7, 2		, Year)
	}	30. Name and address of person wh	o completed cause of deat	h (Item 23a)		O.O.IVI.E.	-			.007	
W		Carol Allan MD Assis	tant Medical Examir	ner 111 F	enn Stre	et, Baltimore, M [21201				
St Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32. Registrar's	14	Sport	8.9					

07-00172		Ple	ease Typ	e or	Print in B	ack In	delible I	nk. E	Ensur	e All C	opies Are L	.egibl	e.	
Heath Wayne St		1- For State	St	ate of	Maryland		irtment o tificate o			d Ment	al Hygiene		20	07 0028
Physicia	n/	Registrar 1. Decedent's Nam	e (First, Middl	e,Last)							2. Date of D			3. Time of Death
Medical Examir	ner	Heath 4a. Facility Name (of not institution		ayne		St	one	Town	Location o	January)7 c. County of De	1950 hrs
		Pulaski Hig	hway at M	artin Bl	vd.				lle Rive		Death		Baltimore C	
Funeral Director	- 1	5. Social Security N 220-04-00		6. Sex	7. Ag	e (In yrs la	ast birthday)	Mont	der 1 Yea hs Day		r 24Hrs. 8. Date of Min. Augus		For	Birthplace (State or reign Cour Maryland
	ŀ	Usual Residence o	f Decedent	Z	2F						nugus	. 22	, 15/1	Court Kall y Land
ow any		10a State Maryland	10b. County Balt	imor	۵		Town or Loca zerlea	tion						10d Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Nu		IIIOI			/CIICa	10f. Zi	p Code			10g Ci	tizen of What C	
h the N		5835 West	wood A	venu	е				2120	16			USA	1
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	 Marital Status Never Marri 	ed 2 XM		2. Was Decedent Armed Forces						in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am White, etc	nerican Indian, Black,
after de	by Fu	3 Widowed		or	res, Give Year Dates:	X No	1_	Yes 2	2 X No	specify:			Specify:	White
2 hours "natur		15. Decedent's Ed		cify only h	nighest grade cor College (1-4 or					tion (Give k e. DO NOT i	ind of work done use retired)	16b.	Kind of Busines	ss/Industry
15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f sh i. the Medical Examiner must be notified at once	Completed	12 years			osnogo (Grap	hix	Desi	.gner			Printin	ıg
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name					_				s Name (First, Middl		,	
212 ould be d Ments s mark	To Be	John Catr 19a. Informant's Na					19b. Mailir	ng Addres	s (Stree		rolette W			ate, Zip Code)
MD and 2 sho alth and em 27 is raumati		Christine 20a. Method of Dis			wife		5835 Place of Dispo	West	WOOO	Aven	ue, Overl			
Baltimore, MD 21215-0036 pormit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Burial 2	X Cremation		Removal from St	ato C	rematory or o	ther place	e)	.	January		Location - City	e City, MD.
Baltimo permit Page Department of Important: injury or oth	H	4 Donation 5	Other Spanneral Service		. ,	20					11, 2007 1 Home Of			- ·
	4	mth	oul	()	nnel	ly	/ 71	10 S	olle	ers Po	int Road,	Dun	dalk,Mo	1. 21222
Physician /Medical		23d Part I. Enter the failure. List on	ly one cause	on each	itions that caused line. ultiple Injuries	0	Do not enter	tne mode	of dying,	, such as ca	irdiac or respiratory	arrest, sh	lock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (or condition resulting		_	e to (or as a cons):							
	Jer	Sequentially list co	nmediate	b Due	e to (or as a cons	equence of	·):		-			 		+
16/	Examiner	cause. Enter Under (Disease or injury the events resulting in	hat initiated	C Due	e to (or as a cons	equence of):						-	
xecurand	cal E	- Investigation		d	MENDED									
10 10		UNPENDED			MENDED 23c. If yes, outco	ne of prear	nancy					122	3d Date of deliv	1000
ox 68760, ath certificate be er attending physician or use as the burial	ian//	23b. Was decedent past 12 months	pregnant in the?	е	1 Live birth Pregnant a		2 F	etal death		Ectopic	pregnancy		Month	Day Year
ക്ക	Physician/Med	1 Yes 2 1	No 9 Uni		9 Unknown		5 O	ther (Spe	ecify)					
	ক্র	Part II. Other signi	ficant condit	ons co	ntributing to deat	h but not re	esulting in the	underlyin	g cause (given in Par				to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rasther death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	Completed										24a. W	as an	24b Were	autopsy findings available
tal Recol	dwo										pe	topsy rformed? s 2 !	death	
tal Fician:	Bec	25. Was case refer examiner?	red to medica	Hos	oital:					of Death (Check only one)			
of Vi ing Physi After this uneral dir	2	1 Yes 27. Manner of Deat	2 No		28a Date of Inju	ıry	ER/Outpatien 28b. Time of		DOA 28c. Inju	ry at Work?		be how in	ence 6 🗸 Oti	
Sion (Meadin death ctor: A the fut	ation	1 Natural 2 Accident	5 Pend	ling tigation	Jan 6, 2007	rear)	1914 hrs		1_	Yes 2	No Driver of	moto	cycle struc	ck by car
Division al or Attences after death al Director: ed in by the	Certification:	3 Suicide	6 Coul	d not be mined	28e. Place of Ir (Specify) Ma				y, office b	ouilding, etc	or Town	, State)		Rural Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.		4 Homicide 29a Certifier (Check only	_	_					e time, da	ate and place	ce, and due to the ca			vard, Middle River, MD
To the within 2 To the complet	Medical			an	n the basis of exa ad manner stated	mination ar	nd/or investiga				surred at the time, da			L.
	2	29b. Signature and	title of certifie	, i	1 . 2			29	o. Licens O.C.	se number M.E.		1.	Date signed <i>(f</i> nuary 7, 200	Month, Day, Year)
		30. Name and	ess of person	who com	pleted cause of	leath (Item	23a)	3 000000						
Q	1 %	Margarita K		Assis	stant Medical			Penn St	reet, B	altimore,	MD 21201			4
St Regist	ate rar	31. Date filed (Mon.	th, Day, Year)	200	32. Registra	rs Signatu	The state of the s	and I	9					

		1	For State Registrar	State of Ma	aryland				lealth a	and M		Reg. No	2007	0.0	284
	ysicia Medic	in al		enhefers							2. Date of Dea Month 01/08/	2007		3	of Death :10 ^{P M}
À Ex	camin		4a. Facility Name (If not institution, giv 1334 Vanderbilt					Bel A					County of Deat		
	neral ector			Sex 7. Ag I□M 2—2 F	e (In yrs. I	ast birthday) Yrs.	Months	or 1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Da 08/26/	h y, Year) 1914	Co	untry)	te or Foreign ed,MD
faryland	is to		Usual Residence of Decedent 10a. State 10b. County MD Harfo	rd	10c. City	, Town or Lo	cation Be1	Air							e City Limits
with the N	De notifi	Direct	10e. Street and Number 1334 Vanderbil	t. Road			10f. Z	ip Code	21014	1		10g. Cit	izen of What Co	untry?	
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene 17atural', or Iteme 23a or 28e-1 ehow	xaniher mus	by Fur	11. Marital Status 1 □ Never Married 2 □ Married ③□ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 25 Hyes, Give Year or Dates:			Was Dec If Yes, sp 1 ☐ Yes	ecify Cuba	ispanic Ori	gin? (Spe	ecrfy Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.	1,
215-0(ithin 72 hou ie.	Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	life.	kind of w DO NOT	ork done d use retired	during mosi 1)	t of worki	ng		ind of Business		
Maryland 21215-0036 td 2 should be filled within 72 hours aff tth and Mental Hygiene. 77 is marked other than "natural", or	c event, the	Be	12 17. Father's Name (First, Middle, Last Unknown	")		Ŀ	OOKK	eeper			(First, Middle,		U.S. St Sumame)	eel	
Marylls nd 2 should lith and Me	r traumatio	으	19a. Informant's Name/Relationship Mary Lou Overhuls		ter	19b. Maili 133							or Town, State, 2		
Baltimore, permit. Pages 1 av Department of Hee	ıry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Co		C	lace of Disponentery, creation House	matory or leigh	other place	(a) (D)		² 2007		ocation - City or ontown,		9
Balt permit. Departri	any inju		21. Signature of Funeral Service Lice	nsee Orota W.(M	arsh	21 0	harl	es T.	ss of Facility Stev Fort	<i>r</i> ens	Funera nue, Ba	l Ho ltim	me Inc. ore, MI	2123	0
Exam	dical	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	ne. nev a consequ a consequ	ntia uence of): uence of):		oe or dyin	g, such as	cardiac c	rrespiratory a	rrest,		Onset a	Between nd Death
9 5	igned by the attending prigorous	by Physician/Medical Ex	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d	of pregna	ncy	□Ectopic □ Other (s	pregnancy	,				23d. Date of de Month	livery Day	Year
ds, P.O. uires that the designed by the	d be detached		9 ☐ Unknown Part It. Other significant conditions		out not resi	ulting in the u	ınderlying	cause giv	en in Part I			obacco Yes 2	use contribute to		of death?
Vital Records, sicien: The law requires to continue to the law requires to the law requires to the law requires to the law requires to the law remains to the law rem	page 2 should	Completed								24a. Was auto perio	psy prior to completion of cause of death?			ngs available of cause of	
of Vita Physicien:	director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospitat:	ent 2 🗆	ER/Outpatie	nt 3 🗆 [Oth Oth			n (Check only o		6 □Other (Spe	icital	
Vision of Attending Physicians of Attending Physicians of Attentions of	e funeral c	ertification; T	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da		28b. Time o		28c. Injur Wor			28d. Describe			ony,	
Division To the Hospitel or Attending within 24 hours after death.	to the rutheral bilector. Also this certificate has completely filled in by the funeral director, page 2	O	3 ☐ Suicide 6 ☐ Could not determined	building, el	tc. (Specify	y) 					City or To	wn, State			Number,
Hosp 124 hot	e runs	edical	29a. Certifier (Check only one) Certifying P (Check only one)	hysician: To the best iminer: On the basis o and manner st	of examina	wledge, dea tion and/or in	th occurre ivestigation	d at the tir on, in my o	me, date ar pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s date an) and manner a d place, and du	s stated. to the cau	se(s)
To th withir	d woo	Me	29b. Signature and title of certifier		UD		2	9c. Licens	e number	(,		_	ite signed (Moni		
,			30. Name and address of person who	- 5		n 23a) (Type	, Print)	_フ ラ	710			JOLY	many Inner	8,20	N T
d.			31. Date filed (Month, Day, Year)	Pd Be	- I A		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2101	4		Julie		TINNEY	ny)
R	Sta legisti		JAN 0 9 2	2007	AR Solyila	5. A	DEAD!								

State of Maryland / Department of Health and Mental Hygiene 17

0	n	2	8	5
	\sim	Lun	\cup	V

		Certificate of Death Reg. No.
	Physician /Medical	1. Decedent's Name (First, Middle, Last) GERALD INE, SLOAN 2. Dete of Deeth Month Day Year 1/35m
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth NORTHAMPTON MANOR - 200 E. 16 TH STREET FREDERICK Frederick
>	Funeral Director	5. Social Security Number 280-28-3660 6. Sex 1 Months 2 Mrs. 4. Age (In yrs. lest birthdey) 7. Age (In yrs. lest birthdey) 7. Age (In yrs. lest birthdey) 8. Days Hours Min. 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. lest birthdey) 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. lest birthdey) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (State or Foreign Country) Ohio
	deeth with the Meryland ms 23s or 28s-f show rmst be notified at	Usuel Residence of Decedent 10a. State
	th with the Me 23a or 28a-f 1 1 Director	10e. Street and Number10f. Zip Code10g. Citizen of Whet Country?200 East 16th Street21701U.S.A.
020	urs efter ii'. or ite ixenine by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Sive Year or Detes: 15. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Yes or No-lif Yes Yes or No-lif Yes Yes or No-lif Yes Yes or No-lif Yes Yes or No-lif Yes Yes or No-lif Yes Yes or No
21215-0020	d within piene.	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) 12 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 10b. Kind of Business/Industry U.S. Department of Health & Human Service
Maryland	ges 1 and 2 should be filed t of Health and Mental Hygi if item 27 is marked other or other traumatic event, I To Be Co	17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edmund Cevasco Marguerite Torok
	1 end 2 sho Health end R em 27 is me other traume	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Douglas Sloan (Son) 5342 Knollwood Dr., Frederick, MD21701
Baltimore,	Peges 1 ement of Heamant: If Item	20a. Method of Disposition 1
Bal	permit. Pege Depertment of important: if any injury or once.	21. Signature of Funeral Service Licensee Donovan-Bagnoli Funeral Home 17 Southwest Ave., Tallmadge, OH 44278
	Physician	23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
	/Medical Examiner ত	Immediate Cause (Final disease or condition resulting in death) a. Churit Olectrutive luny disease Due to (or as e consequence of): Coronary artry disease
,09,	certificate be executed ding physician and sees the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.
ox 68760,		that intered events resulting in death) Last Due to (or as e consequence of):
P.O. Bo	requires that the deeth c	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown
Records,	sw requires s been sign 2 should be pleted b	Reflex disease 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ital R	victon: The la certificate he irector, page:	25. Was case referred to medical 26. Place of Death (Check only one)
sion of Vital	this aid	examiner? Hospital: I Inpatient 2 EP/Outpatient 3 DOA Other: 4 Invasing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 1 Inpatient 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury M 1 Yes 2 No No No No No No No
Division	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)
	To the Hospital within 24 hours or To the Funeral I completely filled	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated. 2 □ Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29b. Signature end title of certifier. 29c. License number 29d. Date signed (Month. Day, Year)
	5 W C O	MD. D00546360 01-02-2007
	15	30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Section 10. House 100 montaine Ave Frederick mb 21701 31. Date filed (Month, Day, Year) () 32. Registrer's Signature
	State Registrar	JAN 0 9 2007 Marin & Access a

		•	For State Registrar	State	of Marylai		artment o		and M		giene Reg. No.	07	00286
	Physicia	an	Decedent's Name (First, Middle, T. COLLET, T. T. T.	•		~~				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	JACQUELINE 4a. Facility Name (If not institution.	FRANCE		JK .	4b City Tour	n, or Location o	of Dogsth	Jan	8 ,	100 7 nty of Death	7:10 A M
	Examin	er	Union Memori	-			-	altimo			40. 000	nty or Death	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Ye Months Da	ar If Under		8. Date of Birt Jan . 1	h v Yearl	9. Birthp	lace (State or Foreign
	Director		219-10-0076 Usual Residence of Decedent	1 □ M 2 □XF	80	Yrs.	WOILING DE	lys Hours	IVIAI.	Jan. 1	5,792	6 Mar	yland
	ow #		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits
	Mary	tor	MD B	altimor	e		Par	kville	9				1 ☐ Yes 🗶 🗓 No
	h with the 23a or 28 at be not	Funeral Director	10e. Street and Number 7912 B. West	morelar	nd Aver	nue	10f. Zip Cod	2123	4		10g. Citizen o	of What Cour US	-
0	permit. Peges 1 end 2 should be lited within 72 hours after death with the Marylend Department of Heath and Mental Hydiene. Important: If them 27 is marked other then "natural", or Items 23a or 28a-f show any njury or other treumatic event, the Madical Examinar must be notified at once.	y Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F	2XINo	1	Was Decedent of Yes, specify 0	of Hispanic Ork Cuban, Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	14. F 8	lace - Americ Black, White, Cify W.	
Ş	hours tural',	ed by	3 Widowed 4 Divorced 15. Decedent*	Year or	Dates:		dent's Usual Oc					Business/Inc	fueta
6171	withln 72 ene. then na he Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) (1-4or 5+)	(Give	kind of work do DO NOT use re rketin	one during most tired)	t of workin	ng		r Ban	•
	ld be filed ental Hygi ked other ic event,	To Be Co	17. Father's Name (First, Middle, L George Lew		:s					(First, Middle,		,	0
ary	and Mari	۲	19a. Informant's Name/Relationsh					reet and Numbe			-		21201
Σ	end 2 lealth m 27 I		James Shock,	Jr-spou		Contract of the Contract of th	The state of the s			-			le, Maryland
Saltimore	Peges 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1			aters B	natory or other	nlace)		2,2007		n - City or To .more,	Maryland
Dail	Dependition of the color of the		21. Signature of Funeral Service L	icensee /	du_			dress of Facility NERAL CATION S	y HAPE ERVI	8800 Es Pa	Harfo rkvill	ord Ro .e,Mary	oad vland ²¹²³⁴
			23a. Part1. Enter the disease, or eshock, or heart failure. List of	complications that only one cause on	caused the dea each line.	ath. Do not ent	er the mode of	dying, such as	cardiac o				Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ aAc	inte R	espira	tory D	restress	<u>, S</u> .	Indro	ME		3 weeks
	Examiner				o (or as a conse	4	C(~	L 8	-0 < 0 0	use Sy	. 1.		America
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due fo	(or as a conse	equence of):	- ca com	23.3		use 19	MBV CW	(4	
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o car of		schem	ia					5 weeks
/6C,	te be execut ysicien and se burial-trar	calE			(UI as a COIIse	squerice (ii).							
	ifficate g phy: as the			O									
C. BOX	ures thet the death certifica signed by the ettending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregr birth 2 ☐ Fel gnant at time of nown	tal death 3	Ectopic pregna Other (specify			<u></u>		Date of delive Month	ory Day Year
ŗ.	requires thet the seen signed by th hould be detache	by Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco use co	ontribute to th	e cause of death?
Sp.	w requires been sign should be									101	es 2 No	3 □ Prob	ably 4 Unknown
Z Z	e law hes b	Completed								24a. Was autop perto 1 Yes	rmed?		psy findings available apietion of cause of
	iiclan: Th certificete rector, paç	Bec	25. Was case referred to medical axaminer? 26. Place of Death. Check only one								20.10		
5	phys this al di	10	1 ☐ Yes 2 ☐ No 27. Manuar of Death			ER/Outpatier	IL SLI DOA			ne 5 Resid			1)
	After fune	tlon	1 VNatural 5 Pending		of Injury nth, Day Year)	28b. Time of Injury	1	Injury at Work? 1 ☐ Yes 2 ☐ I		8d. Describe h	low injury occ	curred	
HVISION	To the Hospital or Attence within 24 hours efter death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of Injury - At I ding, etc. (Spec	home, farm, str cify)	eet, factory, off	ice	2	28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rura	l Route Number,
	Hospite 24 hours Funerel etely fille	edicai C	29a. Certifier 1 Certifying (Chack only one) 1 Medical E	g Physician: To the Examiner: On the and ma	e best of my kr basis of examin nner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in re	se time, date and my opinion, deat	d place, a th occurre	and due to the a	cause(s) and date and plac	manner as si e, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 1	Lygusk	4 . M	D.	į.	cense number	46 6		29d. Date sig	-	
1			30. Name and address of person		use of death (Ite	em 23a) (Type.	Print)	24383. 4 Mei	44.00	ial Ha	اعلن	MI)
	Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Sign	nature	- M -	4 / 1001		1 -1 10	34.61		
	Registi	rar	JAN 0 9	2007	12000 8	O AM	W)						

DHMH 17 Rev 1/200

Schmidt, Catherine N/800332249

Director Direct	IOd. Inside City Limits 1 Yes 2 No ntry? can Indian, etc. ITE dustry
A Facility Name (if not institution, give street and number) Ab. City, Town, or Location of Death A Facility Name (if not institution, give street and number) Ab. City, Town, or Location of Death A Facility Name (if not institution, give street and number) Ab. County of Death A Facility Name (if not institution, give street and number) Ab. County of Death A Facility Name (if not institution, give street and number) Ab. County of Death A Facility Name (if not institution, give street and number) Ab. County of Death A Facility Name (if not institution, give street and number) Ab. County of Death Ab. County	ITE dustry Code)
S. Social Security Number S. Social Security Nu	ITE dustry Code)
Director Direct	ITE dustry Code)
10a. State 10b. County 10c. City, Town or Location 10b. City, Town or Location 10c. City	1 Yes 2 No ntry? can Indian, etc. iTE dustry
See The state of Disposition See The state of Disposition 1	an Indian, etc. ITE dustry Code)
See The state of Disposition See The state of Disposition 1	can Indian, etc. ITE dustry ANY
See The state of Disposition See The state of Disposition 1	etc. ITE dustry PNY Code)
See The state of Disposition See The state of Disposition 1	etc. ITE dustry PNY Code)
See The state of Disposition See The state of Disposition 1	MNY Code)
See The state of Disposition See The state of Disposition 1	MNY Code)
See The state of Disposition See The state of Disposition 1	·
See The state of Disposition See The state of Disposition 1	·
Burial 2 Cremation 3 Removal from State	·
Burial 2 Cremation 3 Removal from State	wn, State
234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one easie on each time. Immediate Cause (Final disease or condition resulting in death) a. Uncontrolled Diabetes Melli ties Due to (or as a consequence of):	
234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one easie on each time. Immediate Cause (Final disease or condition resulting in death) a. Uncontrolled Diabetes Melli ties Due to (or as a consequence of):	MD.
234. Part 1. Enter the disease, or complications that cause) the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one acceptance. Immediate Cause (Final disease or condition resulting in death) a. Uncontrolled Diabetes Mellites Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between
/Medical Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
ff any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
Due to (or as a consequence of): Cause Chiese or injury that initiated events resulting in death) Last Cause Chiese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
ificate be as the bundance of a state of the bundance of the b	
X	
The property of the property o	Day Year
A trial Fibral Barrill. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the Atrial Fibral Barrillo. 1 1 Yes 2 1 No 3 Prob.	ne cause of death?
Atrial Fibrillation 1 Yes 2 No 3 Probi	ably 4 Unknown
The state of the s	psy findings available mpletion of cause of
The state of the s	2 🗆 No
25. Was case referred to medical examiner? 1 Yes 2 No	v)
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?	7
O g = 4 g = 2 Accident investigation M 1 Yes 2 No S = 5 O S = 1 O S	
27. Manger of Death Natural S Pending investigation S Second S	I Houte Number,
The standard of the control of the c	ated.) the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, L	Day, Year)
Musey, ms D57531 JANUARY 0:	8 2007
Money ms J57531 JANUARY 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohit Negr & 601 Veterans Hwy, Suite 204, Millersville,	,
State Registrar 31. Date filed (Month, Day, Year) 32. Degistrar's Signature	nj)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 3. Time of Death 2. Date of Death dent's Name (First, Middle, Last) Month Year **Physician** 2007 0 /Medical City Town, or Location of Death 4c. County of Death Name (If not institution, give street and number, **Examiner** 7. Age (In yrs) last birthday) 8. Date of Birth
(Month, Day, Year)
02-22-1925 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Months Hours 1 M 2 F 231-22-083 81 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10h County "natural", or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
and: If item 27 is marked other than "natural", or items 23a or 28e-1 show and 10 the recomment of the marked other than "natural", or other traumatic event, it a Modical Example of the Incilling at 1 Yes 2 No Severn Director MD Ann Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1893 Place 21144 lle Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) of Defense School Sys. Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) GRAN Minnie NEAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Type, Print) Severn, MD Sample 7893 Bastille Place 21144 husband) ISIAh 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 Ø Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 115 107 Greenmount Cremator Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility YAUGHA C. Greene Funeral Services Baltimore National Pike Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a construence of) Physician/Medical Examiner physician and s the burial-transit To the Hospitat or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a c Division of Vital Records, P.O. Box 68760, 35 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Waknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2010 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 Depatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Diatural
2 Accident 5 Pending To the negree after death, within 24 hours after death.

To the Funeral Director: Af death. investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date/signed (Month, Day, Year) 29b. Signature and title of cer and address of p (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b, c per the 863 1-17-07 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician STEPTOE 824A M ANUARY 2007 RNEST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE IOHNS FLOPKINS | HUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12 05 35 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 □ F Yrs. VA 71 212-34-2620 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at apree. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Y Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 21213 U.S.A. 1222 North Decker Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Armco Steel Co. 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Maude Smith Stewart Steptoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 920 North Luzerne Ave, Baltimore, Md 21205 Jason Steptoe-Son Randall Stown, State Place of Disposition (Name of Date 20a. Method of Disposition King Memorial Park 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/07 Owings Mills, Md Garrison Forest 4 Donation 5 Other (Specify) Marchand Address of Egilly t 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 Imelle Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION HOUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 director, page 2 should be 1 X Yes 2 No 3 Probably 4 Unknown HEMORRHAGE MENINGITIS Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 27. Manner of Death After 1 💢 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours a er death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 5, 2007 D0063682 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WOLFE STREET, BALTIMORE, MD 21287 Marthew 600 Koeni 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 2:00 A M JANUARY Nancy Sequoyah 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1300 North Ave. Baltimore Arbutus If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 8. Date of Birth Month, Day, Year 940 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Mary land 66 Director 219-38-9502 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits To Be Completed by Funeral Director Baltimore 1 ☐ Yes 2 No Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 North Ave. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify Specify: White 3 Widowed 4 Vivorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Mail Clerk Defence Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Coolahan Lillian Stauffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 North Ave. Arbutus, MD. 21227 19a. Informant's Name/Relationship (Type. Print)
Brian K. Sequoyah, son 20a. Method of Disposition Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot
once. Woodlawn Cemetery 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State 01-09-06 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. 21227 Arbutus, M. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SEVERE COPD 20 YRS resulting in death) /Medical Due to (or as a consequence of) Examiner ARTERY DISEASE. 10 YRS CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed 5 YRS. CONGESTIVE HEART FAILURE burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical HYPERTENSION 20 YRSI 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pendin**g** investigation 1 Natural 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063166

JANUARY

MD 21228

720 C, MAIDEN CHOICE LANE, CATONSVILLE JACKSON

4 Pritoch



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Helen Marie Shipley January /Medical 2007 **11:**20 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 309 Little New York Road Rising Sun If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F 185-14-9329 Director 83 Jun. 17, 1923 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner with any injury or other traumatic event, the Medical Examiner with a page. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Little New York Road Funeral 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sosenko Helen Subka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SuAnn Doyle - Daughter 3310 Cedar Church Rd., Darlington, MD 21034 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Cemetery, crematory or other place)
Meadowridge Memorial Bunal 2 □ Cremation 3 □ F 3 □Removal from State 1-6-2007 Elkridge, MD Park Name and Address of Facility Ambrose Funeral Home, Inc. Are of Funeral Service-Licens 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
OVER 3 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): ROME OBSTRUCTIVE LUNG DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine WER 24EARS and al-transit OKLESTIVE HEART To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ASSISTED LIVING 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence ဥ 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 24

Registrar

29b. Signature and the of certifier

31. Date filed (Month, Day,

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), TRPORD Rd SUITE (05 FALLS TON HOW 1947)

29c. License number 000/6389

29d. Date signed (Month, Day, Year) JANUARY 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Yea} Richard E. Smith 2:00 A M January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 3 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1**∑** M 2□ F Maryland 217-34-9766 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Marvland Anne Arundel Lothian 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20711 USA 1324 A Marlboro Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) 12th Λ Mono Type Castman Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Sellman Ernest Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1324 A Marlboro Rd. Lothian, Md. 20711 Joy F. Smith(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □Removal from State Moses Cemetery 1-8-07 Drury, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Windame Redese of Eacilisons Mortuary, P.A. M. Reese MO0483 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) lebsielly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 □Ectopic pregnancy Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1/2 Yes 3 ☐ Probably 4 ☐ Unknown 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed (es death? 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Medical Certification: To

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Be Completed by 25. Was case referred to medical examiner?

1 🗌 Yes

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

4 Homicide

26. Place of Death (Check only one)

5 ☐ Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Injury

28b. Time of

28c. Injury at Work? 1∏Yes 2∏No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🗖 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

ak No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar

Solomons Lsland 31. Date filed (Month, Day, Year) 32. Registrar's Signature 9

07-00001 John F. Simpson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg No. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** F. Simpson 0207 hrs January 1, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore N/A 5. Social Security Number **Funeral** 6 Sev 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs B. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign Months Director Hours 218-90-4218 Davs Min 1**X** M 2 Yrs Country) 6 6 1961 MD Usual Residence of Decedent 10a. State il y 10b. County 10c. City. Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 notified at once. MD N/A Baltimore rector 10e. Street and Number 10f Zip Code 10g. Citizen of What Country or items 23a or ā 202 E. Lafayette Avenue 21202 USA Funeral 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must he Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc 2 Married 2 X No Yes Widowed If Yes, Give Year the Medical Examiner Divorced 1 Yes 2x No specify "natural", Specify Black à 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene than ' 12th N/A chef Burke Cafe' marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be event, Edward Simpson Sr. Mary Pannell Pannell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Precious Simpson-daughter 4909 Edgemere Avenue Baltimore, MD 20a Method of Disposition 2Cb. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 X Burial 2 crematory or other place) Cremation 3 Removal from State mportant: Mt. Carmel Cem 1/12/2007 Baltimore Donation 5 MD Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST la North Avenue Baltimore, MD Part I. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Neck Injury Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Month past 12 months? Yea Pregnant at time of death 5 Other (Specify Yes 2 No 9 Unknown the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? Yes 2 .No ✓ Yes 2 No 25 Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ပ ✓ Yes No Residence 6 28a. Date of Injury (Month Day Year) Jan 1, 2007 Manner of Death 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural Fall down stairs 0140 hrs Pending 24 hours after death. Yes 2 V No To the Funeral Director: in by the 2 🗸 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 237 East Lafayette Street, Baltimore, MD (Specify) Multi-Family Apt Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 1, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🧻 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician ROSALIE J. SIEMER JANUARY 7, 2007 9:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1515 CLEARWOOD ROAD PARKVILLE If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 4/28/1930 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Months 76 192-22-2820 Director PENNŚVYLANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "naturel", or iteme 23s or 28s-1 ehow other traumatic event, the Medical Exerciper must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1515 CLEARWOOD ROAD 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE MAIL HANDLER U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H Be WILLIAM WOLF MABLE SCHWARTZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 DIANA SIEMER/DAUGHTER BALTIMORE, MD 1515 CLEARWOOD ROAD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. METRO CREMATORY, INC. 1/9/2007 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** carunoma of unustain 1/2 years disease or condition resulting in death) netrotatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably , page 2 should 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ № 0 24a. Was an 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funaral Director; A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40850 January 8, 2007 -012 - MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Suare Dr. Bretinir MD 21237 OTTAVIANO MD 9103 YVONNE 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of per-

31. Date filed (Month, Day,

Highway Sw Glen Burnie MD21061

on who completed cause of death (Item 23a) (Type, Print)

208

			For State Registrar	State of M	Maryland		artment o			ind M	ental Hyg	ene 0	07	00297
	Physici	an	1. Decedent's Name (First, Mid				C 1 1				2. Date of Deat Month January	Day	2007	3. Time of Death 6:25PM
	/Medic	cal	Thelma 4a. Facility Name (If not institut.	Mari			Simpki 4b. City, To		ocation o		January		y of Death	0:23FW
7	Examin	ier	Hammonds Lane					ook1					Arun	del
	Funeral Director		5. Social Security Number 215-18-5167	6. Sex 7 1 ☐ M 2 ☐ F	Age (In yrs. Ia 84		ff Under 1 Months	Year Days	Hours	Min.	8. Date of Birth (Month, Day, Dec • 29	,1922	9. Birthp Cour	place (State or Foreign mtry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City,	Town or Lo	ocation						1	0d. Inside City Limits
	e Man a-feh	ctor	MD Anne	Arunde1	Glen	Burn	ie							1 ☐ Yes 2X No
	vith th	Funeral Director	10e. Street and Number				10f. Zip C				11	og. Citizen of		ntry?
	eeth v	era	205 Wilson Blv 11. Marital Status	d 12. Was Decede	ent Ever in U.S	3. 13.	2106 Was Deceder		panic Orio	in? (Spe	cify Yes or No-		S.A.	can Indian,
36	filed within 72 hours after deeth with the Maryland Hygiene. sther than "neturel", or Iteme 23a or 28a-f ehow ent, the Medical Exantiner must be notified at	by Fun	1 Never Married 2 M 3 Widowed 4 Divorc	Armed Force 1 ☐ Yes 2 If Yes Give	s? ∑No		If Yes, specify			, Puerto I	ocify Yes or No- Rican, etc.)	Speci	ack, White, ify: Wh	^{etc.} ite
21215-0036	72 hours "neturel",	Completed	15. Deced (Specify only high	ent's Education nest grade completed)		(Give	dent's Usuaf (kind of work DO NOT use	done du	tion uring most	of worki	ng	16b. Kind of I	Business/In	dustry
2121	s 1 and 2 should be fited within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "netur other treumatic event, the Madical	omb	Elementary/Secondary (0-12) College (1-4d	or 5+)	Homem		retirea				Own	Home	
pu	be filed ntal Hyg od othe event,	Be	17. Father's Name (First, Middle	e, Last)							(First, Middle, M	laiden Suma	ime)	
Maryland	should hd Mer marke imatic	ှင	Casper Ries 19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (S	Street ar	Lula nd Numbe		l Route Number	City or Town	n, State, Zip	Code)
	alth ar 27 is		Mr. John F. S		/Son	200	Rooser	ve1t	t Ave	nue	Glen Bu	rnie,	MD 21	061
Baltimore,	permit. Pages 1 el Depertment of Hea Importent: if Item eny Injury or othe gase.		20a. Method of Disposition 1 MBurial 2 □Crematio 4 □Donation 5 □Other		ate ce	metery, cre	osition (Name matory or othe en Mem	er place,		Jan. 200	13,	20c. Location Glen B	-	
Balti	permit. Pages Depertment of Importent: If II eny Injury or o		21. Signature of Funeral Service	ce Licensee	M0/3						gleton : Glen Bu			
8760,5	Physician //Medical Examiner per partial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	anca of):	4).	we	m T	رفر			Onset and Death S/LCOC
P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funerel Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		t at time of de	death 3	□Ectopic preg □ Other (spec						ate of deliver	ery Day Year
	ires that signed b	þ	Part II. Other significant cond	itions contributing to deat	th but not resu	Iting in the u	inderlying cau	se giver	n in Part I.		23e. Did tob		/	he cause of death?
of Vital Records,	ne law requii nes been s ge 2 should	Completed	Hyp	tanse	~M						24a. Was a autops perform	y	prior to co death?	psy findings available mpletion of cause of
tal	nn: The	0	25. Was case referred to medi	cal					26 Place	of Death	1 Yes 2	1 AMO	1 Tyes	2□ No
Ϋ́	nysicie nis cer direct	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ fnp	atient 2 🗆 E	ER/Outpatie	nt 3□ DOA	Other			me 5 ☐ Reside		ther (Specif	5)
ion o	nding Pt ath. r: After the e funeral		27. Manner of Death 1 Avatural 5 Pen 2 Accident inve	ding 28a. Date of the (Month, stigation)	fnjury Day Year)	28b. Time o Injury	of 280	Work?	at ? es 2 □		28d. Describe ho	w injury осса	urred	
Division	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:			Injury - At hos, etc. (Specify,		reet, factory, o	office			28f. Location (St City or Town		nber or Rura	al Route Number,
	Nospit	Medical (29a. Certifier 1 Certification (Check only one)	ying Physician: To the be al Examiner: On the basi and manner	s of examinati	vledge, deat ion and/or in	th occurred at ivestigation, in	the time	e, date an inion, dea	d place, a	and due to the ca ed at the time, d	tuse(s) and nate and place	nanner as s e, and due t	stated. the cause(s)
	To the To the comp	M	29b. Signature and title of cert	fier	7		29c. I	License	number		2	9d. Date sign	ned (Month,	Day, Year)
			1//5	, and	mo	>		DE	310	44	1	1/8,	1200	07
	lo		30. Name and address of pers H. George He	on who completed cause of bard M.D. 47				211 -	D. 1.	·	. MD 214	7 /		
	Sta	ate	31 Date filed (Month, Day, Ye	ar) @ 32 Reg	istrar's Signat	nie	on Ave	nue_	ратт	TINOT	e ru Zl.	220		
	Regist		IDN 0 9 2	007 Break	15.	The state of the s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend \$a, perMD, 10a,19a, perFH, 6863 ertificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JANUARY 4, 2007 a FANNIE STIEFEL 8:15 Рм /Medical 4a. Facility Name (If not institution, give street and number)
8710 CARRIAGE HILL ROAD 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
OLAND 5. Social Security Number 6. Sex 8. Date of Birth Month Day Year) 06/28/1907 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗸 F 99 130-03-5798 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Ħ ral", or Items 23a or 28a-f sh Examiner must be notified Director HOWARD 1 ☐ Yes 2 📉 No MD COLUMBIA Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 CARRIAGE HILL DRIVE 21046 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🛣 No WHITE þ 3 Nidowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. **SEAMSTRESS** CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATIS NEMETH CHAJADENA FRIEDLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8710 CARRIAGE HILL DRIVE - COLUMBIA, MD 21046 19a. Informant's Name/Relationship (Type. Print) DAVID SCHWARTZ / GRANDSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗡 Removal from State MT. ZION CEMETERY 01/07/2007 4 ☐ Donation 5 ☐ Other (Specify) MASPETH, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1, Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** 10 muntes /Medical Due to (or as a consequence of): Examiner 20 455 Arterio sclerosa Sequentially list conditions Examine it any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria pe e Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year P.0. 5 Other (specify) 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 No Minown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has perform certificate 2 No 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospital or Attending 1 Matural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D17821 ·mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cilicatt City MD 21142

State Registrar Ress

Varren

31. Date filed (Month, Day, Year)

Nall

Dor siy

4801

32 Registrar's Signature

Drue, 5.201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4, Arthur D. Smith Jan. 2007 P^{M} 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Halethorpe Baltimore 2849 Louisana Avenue 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 212-20-4522 81 Director Jul. 4, 1925 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland | Baltimore 1 Yes 2 No Director Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2849 Louisana Avenue 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n Electrician Mfq 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health ar nt; if item 27 is 1. 1338 Sulphur Spring Road, Halethorpe, Maryland 21227

ce of Disposition (Name of Date 20c. Location - City or Town, State Arnold R. Silbeger / Attorney 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4 □Donation 5 □ Other (Specify) Loudon Park Cemetery 1/8/2007 Baltimore, Maryland 21. Ignature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCUAR MINUTES /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION O YEARS Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit requires that the death certificate be executed 10 YEARS HYPERCENSION Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. physician Physician/Medical the aftending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? Yes 2 No ate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ġ this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0

KUSSELL E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HILLSEY,

32. Registrar's Signature

0+1

MD SUME 300,

MD

29c. License number

D50533

3449 WILKERS AVE,

29d. Date signed (Month, Day, Year)

BAUTIMORE, MD 21229

Registrar

DHMH 17 Rev 1/2001

State

N. Charles ST Bosamne no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMES MS

6701

32. Registrar's Signature

AMON J. (

JAN 0 9

31. Date filed (Month, Day, Year)

			Please					delible Inka artment of F					•) .	
		_	For State Registrar				-	rtificate of		h		Reg. No		7	10301
	Physici /Medic		1. Decedent's Name (First, Middle, La Ruth C. Tawney	st)							2. Date of De Month JANUA	eath Da	7, 20	ar	Time of Death
	Examin		4a. Facility Name (If not institution, given Saint Joseph	re street and nu Medic	mber)	Cent	er	4b. City, Town, o		n of Death Towso	n		. County of D	eath ltim	ore
N	Funeral Director			Sex I□M 2 7 F	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	s Min.	8. Date of Bir (Month, Da	ay, Year,	1000	Country)	(State or Foreign
	D		Usual Residence of Decedent				Town or Lo	Landing			January	19,	1922 M	aryla	
	ne Maryla 8a-f shov ptiffed at	ector	MD 10b. County Baltim	ore			wson							1	Side City Limits
	23a or 2 ust be n	Funeral Director	10e. Street and Number 509 E. Joppa Rd.					10f. Zip Code 21286					tizen of What USA	: Country?	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dec Armed F 1 ∐Yes If Yes, G Year or D	orces? 2 ∏ √o ive			Was Decedent of HIF Yes, specify Cub			ify Yes or No lican, etc.))-	14. Race - A Black, W Specify: W	/hite, etc.	dian,
Baltimore, Maryland 21215-0036	I within 72 ho jiene. r than "natui the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College ()	(Give life.	dent's Usual Occup kind of work done DO NOT use retire ultant	pation during m d)	ost of workin	g	Von	Paris Paris Pany		
yland	12 should be filed w h and Mental Hygie r is marked other t raumatic event, th	To Be C	17. Father's Name (First, Middle, Las Nicholas Cockey						Gr	ace Ro					
Mar	and 2 sh ealth and n 27 is m		Jon Tawney- Son	Type, Print)				ng Address (<i>Str</i> eet Old York						te, Zip Code	e)
nore,	Pages 1 a nent of Hez nnt: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State	St. cer	ce of Disponetery, cre	osition (Name of matory or other plass Episcop			ate	20c. L	ocation - City		
Baltii	permit. Pag Department Important: Il any injury o		21. Signature of Funeral Service Lice			Cerie	etery Be	2. Name and Addre	ess of Fac Moort			l Cha	pel & C	rematic	n Service:
,09	Physician /Medical Examiner	al Examiner	23 Part Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CON Due to COR Due to	(or as a (or as a	TIVE	HEA	RT FAIL Y DISEA	URE	as cardiac or	respiratory a	arrest,		Appi Inter Ons	roximate rval Between et and Death
P.O. Box 687	The law requires that the death certificate to the law been signed by the attending physicage 2 should be detached for use as the total to the law that the law t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, ou	birth 2 nant at ti	of pregnand 2 □ Fetal of ime of dea	leath 3	⊒Ectopic pregnanc □ Other (specify) _	ey .				23d. Date of Month	delivery Day	Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to	death but	t not result	ing in the u	nderlying cause giv	ven in Pa	rt I.			use contribut		1
Division or Vital Records,		Completed		T							1□ Yes	psy ormed? 2 N	prior deat	to completi h?	ndings available ion of cause of No
<u> </u>	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatien	t 2□E	R/Outpatie	nt 3□ DOA Oth	oer.		<i>(Check only o</i> ne 5 □ Resi		6 □Other (S	Specity)	
0 UC	ding Ph J. After th funeral	L:uoi	27. Manner of Death 1 Matural 5 ☐ Pending		of Injury	Year) 2	28b. Time o Injury	Wo	ry at rk?	2	Bd. Describe				
Divisio	if or Attending Physician: after death. I Director: After this certifica d in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	e 28e. Plac	e of injur ding, etc.	ry - At hom (Specify)	ne, farm, sti	M 1 □	Yes 2		3f. Location (City or To	Street a wn, Stat	nd Number or e)	r Rural Rou	ite Number,
	To the Hospital or At within 24 hours after d To the Funeral Directormpletely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	miner: On the	e best of basis of o	examinatio	ledge, deat on and/or ir	h occurred at the ti	ime, date opinion, d	and place, a death occurre	nd due to the	cause(s	s) and manne nd place, and	r as stated. due to the	cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Zew	5			> 29c. Licens	se numbe			29d. Da	ate signed (M	onth, Day,	Year)
1	7		30. Name and address of person who	_	ise of dea	-		Print)					1	*	
	Sta	ite	BOON POH LIM. 31. Date filed (Month, Day, Year)			<u>6 Ø 1</u> r's Signatu	OSLE ire	R DRIVE	TOL	VSON,	MARY	LAN	D 212	214	
DHI	Regist	- 25	JAN 0 9	2007			A	sell .							

	1- For Amend #17, perFH, \$\frac{\text{State of Maryland / Dep}}{C6}\$	artment of Health and Mental F	Hygiene Reg. No. 007 00302
Physician	Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day Year (1, 100 0)
/Medical	Virginia Lee luiner	4b. City, Town, or Location of Death	4c. County of Death
Examiner	ANNE ARWDEL MEDICAL CENTER	Annapolis	Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date of	
Director	216-30-6729 ^{1□M} 3 □F 75 Yrs.		4 1931 Maryland
pue *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Maryita f sho		is	1 _X Yes 2 □ No
with the Maryland a or 28a-f show be rigitilised at Director	Maryland Anne Arundel Annapol	10f. Zip Code	10g. Citizen of What Country?
death with the Maryland rms 23a or 28a-f show rmat be routhed at neral Director	110 Holeclaw St.	21401	USA
fier death virtues 23th tree must	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
J36 irs after		1 ☐ Yes 2 ☐ No Specify:	Specify: Black
		edent's Usual Occupation	16b. Kind of Business/Industry
21215-00 ed within 72 hou yojene. The Medical t, the Medical Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	
d with giene ar the	12th 0	Custodian	Anne Arundel Co.
be file by od outh od outh	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	
Ylan nould I Men narke narke		Mary E. Car	-
Maryland d 2 should be file th and Mental Hy 27 is marked oth traumatic event	19a. Informant's Name/Relationship (Type, Print) 19ames V. Turner Sr. (Husband) 11	•	
Hear Hear other		osition (Name of Date	20c. Location - City or Town, State
Pages ent of nt: If I	1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Memoria		Annapolis, Md.
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If them 27 is marked other then "nu any highry or other traumatic event, ins Mental once. To Be Complet	21. Signature of Funeral Service Licensee Zavry J. Reese MOS 483	vm ^{Name} Redese of Earlisons Mor 321 West St. Annapol	tuary, P.A. is, Md. 21401
	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		
Physician	Immediate Cause (Final disease or condition		Onset and Death
/Medical	resulting in death) Due to (or as a consequence of):	2	
Examiner		arction	
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cardiovascular Di	D2 29
760, be executed sicien and burial-transit	that initiated events resulting in death) Last c. Due to (or as a consequence of):	Careful agents	
760, te be ex ysicien ne buria			
68 tilicat as the			
vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifical ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th filcation: To Be Completed by Physician/Medi	FFEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy	23d. Date of delivery Month Day Year
O. E. de dea	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 1 Yes 3 Yes 4 1 Yes 4 Yes	Other (specify)	
P.O.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. C	Did tobacco use contribute to the cause of death?
d by			☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
I Record The law requir cate has been si page 2 should	Delator	24a. V	Vas an 24b. Were autopsy lindings available
Re(he lav	Jageres 3	p	utopsy prior to completion of cause of death?
Vital F ician: Th certificate rector, pag		1 ☐ Ye 26. Place of Death (Check or	
hysici hysici his cer il direc	examiner? 1 Yes 2 No Hospital: 1 npatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Home 5 F	Residence 6 Other (Specify)
sion of Vital Rectending Physician: The tax tending Physician: The tax for After this cartificate has the funeral director, page 2 carton: To Be Comp	27. Manny of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	Work?	the how injury occurred
isio Ntendi death. ctor: A y the fc	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury At home farm	M 1 Yes 2 No	on (Street and Number or Rural Route Number,
Division of Vital Records, tall or Attending Physician: The law requires the staffer death. In prector: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by	28e. Place of Injury - At home, farm, so building, etc. (Specify)		Town, State)
Hospital or 24 hours afte Funeral Dir itely filled in			
Division To the Hospital or Attent within 24 hours after destite to the Funeral Director: completely filled in by the Medical Certifical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at the tii	me, date and place, and due to the cause(s)
within to the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Dalnatore J. Laura u	D D41034	January 1, 2007
	30. Name and address of person who completed cause of death (Item 236) (Typ 128 LUBRANO DRIVE SUITE 300		-
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ANNAPOLIS MD, 2140/	
Registrar	10110000007	Speciel	

December in the medical part of the control				1 - For State Registrar	e of Mary	land / De		t of H	ealth a				007	003	03
State State Same Services Formation Form	100	raging a									2. Date of Deat		V	3. Time of	Death
Examiner Function Protect Director Function Protect Director Function Protect Director Function Protect Director Function Fu				James Ellsworth Tho:	rpe						January	6,	2007	2:00	Рм
Social Services Number Class Cla	1									f Death					
The property of the property o	1	· · · · · · · · · · · · · · · · · · ·								DA Hrs	9. Data of Birth	Ca		ala a a /Ctata a	. Coming
State Stat						-	Months				(Month, Day,	Year) 1026	9. Birth		roreign
Total Price Name First, Middle, Last) Total Representation	1650	D		Usual Residence of Decedent							1100 0,	1)20			
Total Price Name First, Middle, Last) Total Representation		anylar show id at	ž		1	-									
Total Price Name First, Middle, Last) Total Representation		the M	ecto					Codo			1	Do Citizor	of What Cau		- 22.10
Total Price Name First, Middle, Last) Total Representation		Sa or			st Apt 3	8-A						-		itu y :	
Total Price Name First, Middle, Last) Total Representation		death	nera	11 Marital Status 12. Was	Decedent Ever		13. Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No-		Race - Ameri		
Total Price Name First, Middle, Last) Total Representation	9	after or ite		1 Never Married 2 Married 1 X	Yes 2 □ No					, rueno	nican, etc.)	So		etc.	
Total Price Name First, Middle, Last) Total Representation	8	hours urel',	d b	3 Awidowed 4 Unvorced Yea	r or Dates: 19								Whi		
Total Price Name First, Middle, Last) Total Representation	7	in 72	oiete	(Specify only highest grade compl		(G	ive kind of wor	k done a	turina most	of worki	ng	16b. Kind	of Business/Ir	idustry	
Physician Middical Examiner 23a Part I. Erise the disease, or despite fillow. List offy one cause of each fillow. List office cause of each fillow. List office cause of	212	d with giene.	E o		ege (1-4or 5+)	Truc	ck Driv	er				Trucl	king Co	mpany	
Physician Middical Examiner 23a Part I. Erise the disease, or despite fillow. List offy one cause of each fillow. List office cause of each fillow. List office cause of	b	e filed al Hyg l othe vent,		17. Father's Name (First, Middle, Last)					18. Mothe	r's Name					
Physician Middical Examiner 100000000000000000000000000000000000	<u>ya</u>	Menta Menta arked	2					<u>_</u>							
Physician Middical Examiner 100000000000000000000000000000000000	Jar	and raum					_								
Physician Middical Examiner 100000000000000000000000000000000000	e)	1 and Healtl em 27 ther t		•											
Physician Middical Examiner 100000000000000000000000000000000000	o D	ages ant of t: if it		1 ☐ Burial 2 X Cremation 3 ☐ Removal	Irom State										
Physician Middical Examiner 100000000000000000000000000000000000		nit. P artme ortan injuri										salt1	more, l	MD	
Physician Pinysician P	ñ	Deg in se		· Class	Todd D	ring	MacNab	Ut d eder	mera!	HON Ca	e, P.A.	10 N	رام در 122	Q	
Physician (Mach) The property of the property			(23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the	death. Do not	enter the mode	e of dying	g, such as	cardiac c	r respiratory arre	st,	110-2122	Approximate Interval Bety	ween
Due to (or as a consequence of): Control		Physician		Immediate Cause (Final disease or condition										Onset and [)eath
Sequentially list conditions, Sequentially list conditions,				resulting in death)	ue to (or as a co	nsequence of):									
Due to (or as a consequence of): The control of the control of			-	Sequentially list conditions, b	ue to (or as a co	nsequence of):					· · · · -				
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a	/	uted d ansit	Ë	Cause. Enter Underlying Cause (Disease or injury									11		
The state of the s	o O	an an		resulting in death) Last	ue to (or as a co	nsequence of):									
FFEMALE 23c. If yes, outcome of pregnancy 1 1 ves in the past 12 months? 2 ves in		¥ > 9		d											
OC 1 STATE STATE OC 2 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE	9 ×	ding p	/Mec		s outcome of pr	regnancy/								-	
OC 1 STATE STATE OC 2 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE STATE OC 3 STATE	Bo	atten for us	clan	in the past 12 months?	Live birth 2 🗌	Fetal death						23d			'ear
25. Was case referred to medical examiner?	o.	t the d	hysi		Unknown										
25. Was case referred to medical examiner?	S,	ss tha		01 11	g to death but no	t resulting in th	e underlying ca	ause give	en in Part I.		23e. Did tob	acco use	contribute to t	he cause of d	eath?
25. Was case referred to medical examiner?	ord	is uee	ted	Bladder tumor							TY	s 2 🗆 N	lo 3 Prol	oabiy 4 □U	nknown
25. Was case referred to medical examiner?	ě	has be	npie	Lung concer							autops	4	prior to co	psy findings a	availabte ause of
286. Place of Injury - At home, farm, street, factory, office 287. Cocation (Street and Number or Rural Route Number, 288. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 290. Cation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number, 292. Cation (Street and Number or Rural Route Number, 293. Cocation (Street and Number or Rural Route Number, 294. Cocation (Street and Number or Rural Route Number, 295. Cocation (Street and Number or Rural Route Number, 296. City or Town, State) 297. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number) 291. Cocation (Street	a H	n: The		V							1□ Yes 2	Ø No		200 No	
286. Place of Injury - At home, farm, street, factory, office 287. Cocation (Street and Number or Rural Route Number, 288. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 290. Cation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number, 292. Cation (Street and Number or Rural Route Number, 293. Cocation (Street and Number or Rural Route Number, 294. Cocation (Street and Number or Rural Route Number, 295. Cocation (Street and Number or Rural Route Number, 296. City or Town, State) 297. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number) 291. Cocation (Street	Ħ	siciar certif irecto	0	examiner?	Mination	2 [[F []]]	2000	Othe	200				1011 (0		
286. Place of Injury - At home, farm, street, factory, office 287. Cocation (Street and Number or Rural Route Number, 288. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 290. Cation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number, 292. Cation (Street and Number or Rural Route Number, 293. Cocation (Street and Number or Rural Route Number, 294. Cocation (Street and Number or Rural Route Number, 295. Cocation (Street and Number or Rural Route Number, 296. City or Town, State) 297. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number) 291. Cocation (Street	ō	g Phy er this	-	27. Manner of Death 28a.	Date of Injury	28b. Tim	e of 2	8c. Injury	at at					(y)	
286. Place of Injury - At home, farm, street, factory, office 287. Cocation (Street and Number or Rural Route Number, 288. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 289. Cocation (Street and Number or Rural Route Number, 290. Cation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number, 292. Cation (Street and Number or Rural Route Number, 293. Cocation (Street and Number or Rural Route Number, 294. Cocation (Street and Number or Rural Route Number, 295. Cocation (Street and Number or Rural Route Number, 296. City or Town, State) 297. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 298. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 299. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 290. Cocation (Street and Number or Rural Route Number, 291. Cocation (Street and Number or Rural Route Number) 291. Cocation (Street	ion	ath. rr: Aft	atio	2 Accident investigation	(Month, Day Yea	ar) injui				No					
29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Ahemo M.D. 2007 32 Registrar's Signature 29c. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Ahemo M.D. 200 Memorial Avenue Westminster, MD 21157 State 31. Date filed (Month) Day, Year) 20c. Registrar's Signature	<u> </u>	r Atterde	rific	determined 289.	Place of Injury - building, etc. (S	At home, farm, pecify)	, street, factory	, office		- 1			umber or Rur	al Route Numi	5e <i>r</i> ,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Atherno M.D. 200 Memorial Avenue Westminster, MD 21157 State 31. Date filed (Months Day, Meal) 2007 32 Registrar's Signature	Ω	pitel c urs af erai D		***************************************											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Athemo M.D. 200 Memorial Avenue Westminster, MD 21157 State 31. Date filed (Month Day, Most) 2007 32 Registrar's Signature		24 ho 24 ho Fun etely f	dica	(Check only 2 Medical Examiner: On	the basis of exa	y knowledge, d mination and/o	eath occurred a or investigation,	at the tim in my op	ne, date and pinion, deat	h occurr	and due to the ca ad at the time, da	iuse(s) an ite and pla	d manner as s ace, and due t	stated. o the cause(s)	,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Atherno M.D. 200 Memorial Avenue Westminster, MD 21157 State 31. Date filed (Months Day, Meal) 2007 32 Registrar's Signature		ro the within romple	Me				29c	. License	a number		2	d. Date s	igned (Month,	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Athemo M.D. 200 Memorical Avenue West minster, MD 21157 State 31. Date filed (Months Car. Months Car. Months Car. Months Signature)				I the the		M.D	. D	00	619	21		Janu	ary 6,	200	7
State 31. Date filed (Month) Day, Meal: 2007 32 Registrar's Signature		P				(ttern 23a) (Ty	pe, Print)	·) = :			-		
JAN U & ZUUI JASSA JA		V			149	- 1	ngrici	Avenu	مو	west	minster	1 ANTZ	7112	7	
Registrar				ST. Date fled (MOTHER Day, 1984) 7007	negistrar's S	Signature State	A CONTRACTOR OF THE PARTY OF TH								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 P M Carolyn Javone Turner Jan. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2410 Annor Ct. Baltimore n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, FEB 14, 5. Social Security Number 9. Birthplace (State or Foreign Country) North Carolina 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1957 1 ☐ M 2 💢 F 49 217-70-2280 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 √Yes 2 No Director MD N/A **Baltimore** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a or ? 2410 Annor Ct 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Black þ 3 Widowed 4 Divorced th and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical ! Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Jolly Virginia Jolly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other training. 4101 Hyden Ct Brooklyn, MD 21225 Asia Turner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 1/8/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STACE ue to (or as a conservement) 5 YEARS /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral idrector, page 2 should be deteched for use as the burial-trans! Division or Vital Records, P.O. Box 68760,

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [☐ER/Outpatient 3☐D	OOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigat		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street, facto	ory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, le)
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kr aminer: On the basis of examination and manner stated	nowledge, death occurre nation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)

29c. License number

20051412

29d. Date signed (Month, Day, Year)

01-08-07.

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nahid F. Siddiqi 631 Cherry Hill Rd Baltimore, MD 21225

31. Date filed (Month, Day, Year) State Registrar JAN 0 9

29b. Signature and title of certifier

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 17:30 PM avasori 2007 Januar /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Himore 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 267-90-526 Usual Residence of Decedent Months 56 Yrs Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Baltimore 1 No 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21230 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, 1 Never Married 2 Married 2 No 1 🗌 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) ath 17. Father's Name (First, Middle, least) 18. Mother's Name (First, Middle Be ouis Vavasori Depertment of Health an Important: If item 27 is n any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vavasori/Daugher 10 N. Kenwood altmore 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 Decremation Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State Jan. 9, 2007 Moun 5 ☐ Other (Specify) 4 ☐ Donatio green ne and Address of Facility Service 21. Signature of Funeral Service 22. Na 5151 Baltmore Nat'l Pile, Balto., MD 21229 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he had ailure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician days /Medical Due to (or as a consequence of) Examiner inteneous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine as the burial-transit cate has been signed by the attending physician , page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? cartificate Vital 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X** No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA oţ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 2 Accident Injury 5 Pending 1 □Yes 2 □No within 24 hours after death. To the Funerel Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier cal (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19509 ledica 30. Name and add 65s of person who completed cause of death (Item 23a) (Type, Print) 900 Avenue Catan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 14 200 -**Physician Evelyn A Wesley** 1:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Baltimore Forest Haven Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M **X**□F Yrs Director 220-22-2446 Apr 3, 1930 No. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov the Medical Examiner must be notified at 1X Yes 2 No Director N/A **Baltimore** Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3600 West Franklin Street iteme 23a 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 Yes 2 No Specify ð Black 3 ☐ Widowed 4 ☑ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental h is marked Unknown Robinson Anna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 4621 Shamrock Avenue Baltimore, Maryland 21206 Gwendolyn Weeks Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Depertment of H
Importent: if its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/07 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Liters 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the pisease, or sond shock, or heart silure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** TERMINAZ /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. The underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) signed by the ettending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Onknown 1 □ Yes 2 □ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed? Yes 2 No certificete 2 No 1 Tes 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) ě 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending Injury death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the e the th 29b. Signature and title of certifier 29c. License number 0 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Pay Heights Anonice 7220 wan 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 9

21215-0036

Baltimore,

P.O. I

Records,

Division of Vital

			Please 1	Type or Print				-	_	ole.
			For State Registrar	State of Mai		artment of ertificate of		nd Mental Hy	giene Reg. No:	7 00307
	Dhamini		1. Decedent's Name (First, Middle, Last)			-	2. Date of De Month	ath Day	3. Time of Death
1	Physicia /Medic			Wallace				JANHAR	y 4 2	007 09:50 PM
	Examin	er	4a. Facility Name (If not institution, give		(a.tan	4b. City, Town,	Burni		4c. County	
-			Baltimure Washing 5. Social Security Number 6. Se	11	(In yrs. last birthday	If Under 1 Yea	r If Under 24	4 Hrs. 8. Date of Birt	h	9. Birthplace (State or Foreign
	Funeral Director			TM 2FF	68 Yrs.	Months Day	s Hours	Min. (Month, Da 7-22-19	y, Year) 938	Country) Ohio
100	P .		Usual Residence of Decedent							40d Inside City Limite
	show dat	<u>.</u>	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland 'natural', or Items 23a or 23a-f show dr.al Examiner must be notified at	Funeral Director	Maryland		Baltimor				10g. Citizen of W	
	a or 2	Ë	10e. Street and Number			10f. Zip Code				Mat Country:
	eath is 23	eral	600 Light St., Ap	t /21 12. Was Decedent Ev	er in U.S. 13.	21230 Was Decedent of	Hispanic Origi	n? (Specify Yes or No	USA - 14. Race	e - American Indian,
"	r Iten	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2000		If Yes, specify Cu	ıban, Mexican,	Puèrto Rican, etc.)	Blac	k, White, etc.
5-0036	ral", o	by	3€XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XXN	o Specify:		Specify	White
5-0	72 h 'natu dical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Giv	edent's Usual Occ e kind of work don	e during most o	of working	16b. Kind of Bu	siness/Industry
2121	vithin sne. than '	шb	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retii	rea)		~ 1 t	D4 433
d 2	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ပ္ပ	17. Father's Name (First, Middle, Last)		Clerk		18. Mother	s Name (First, Middle,		Distillery
an	id be lental ked o	To Be	Raymond C. Davis				Gertri	de Truitt		
Maryland	should and Men s marke umatic	-	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mail	ing Address (Stre		or Rural Route Numb		State, Zip Code)
	and 2 salth a 27 is		Billie Jo O'Donova	n-daughter			ok Rd.,	Glen Burr	nie, MD	21061
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	lace)	Date	20c. Location -	City or Town, State
Ë	. Pag tment tant: jury c		4 Donation 5 Other (Specify,)	Meadowridg			-8-2007	Elkridg	e, MD
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		21. Signature of Funeral Service Licens	see		22. Name and Add arv L. K		Funeral Ho	ome at M	MP, INC.
	E0 = 60		23a. Part1. Enter the disease, or comp	lications that caused t	he death. Do not er	250 Wash	ington	Blvd., Ell	ridge ,	MD 21075 Approximate
	Division		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line			,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	Consequence of):	J				
	Examiner			Crohr	u's Dis	CASC				
	P	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	consequence of):					
	ecuted and transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	c						
90,	©	úì	resulting in death) Last	Due to (or as a	consequence of):					
68760,	certificate be ex Iding physician Ise as the burial	dica		d						
9 X	certif ding se a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p					23d. Dat	e of delivery
Box	death e atten	iclar	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at t		□Ectopic pregnar □ Other (specify)			Moi	
P.0.	t the	hys	9 ☐ Unknown	9□Unknown						
	w requires that the sbeen signed by the should be detached		Part II. Other significant conditions co	ontributing to death but	not resulting in the	underlying cause	given in Part I.			ribute to the cause of death?
ord	equir sen si ould I	ted						1	Yes 2 No	3 Probably 4 Unknown
ec	as be	Completed by						24a. Was auto	osy p	Were autopsy findings available prior to completion of cause of
э Н	ate pag	Con						1□ Yes	ormed2 c 2. No 1	death?
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:)ther:	of Death (Check only o		
ō		: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time	SILL SUIDON	4 LI NUI:	sing Home 5 Resi	dence 6 ∐Otho how injury occurr	
lon	Attending Phradent restor: After the sctor: After the type the funeral	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		/ork? □Yes 2□N	0		
Division or	r Attendl er death. rector: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At home, farm, s (Specify)	treet, factory, offic	e	28f. Location (City or To	Street and Number	er or Rural Route Number,
	urs aft urs aft ural DI					AL	4-4	Inland of the state of the stat		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		ysician: To the best of ilner: On the basis of and manner state	examination and/or					nner as stated. and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and mailler state		29c. Lice	nse number		29d. Date signed	d (Month, Day, Year)
	F \$ F 8		1 Henry for	tun.D		Do	2741	5	Journ 4	, 2007

State

Registrar

JAN 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENCY |-RANCIS MD, Baltimore Washington Melical Confer

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryiand 7 Department 97 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 20078 White William R. DAMuary 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAIMT CINE HOSPITAL ear | If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** Months Days **X**☐M 2☐F Hours Yrs. Ф5 02 MD Director 220-22-8356 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show must be notified at 1 X Yes 2 No Baltimore MD NA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 may Injury or other traumatic event, the Medical Examiner must be none. 21229 U.S.A. 39 North Kossuth Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Black þ X□Widowed 4□Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Brake College (1-4or 5+) Elementary/Secondary (0-12) and Allignment Auto Mechanic 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Thomas Goodvine Clara White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 818 Hopewood Road, Pikesville, Md George White-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1√ Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Garrison Forest Vet 1/10/07 Owings Mills, Md March F/H West 21. Signature of Funeral Service Licensee reere 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final noselerotic Vasculer **Physician** disease or condition resulting in death) oronary /Medical Due to (or as a comm quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ned by the attending physician and a The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown nis certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1□ Yes 2☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 | Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death

To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A A Superistrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 9

DHMH 17 Rev 1/2001

ORIGINAL

07-00013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

viima vviiliams		1- For State Registrar	tate of Maryland		tment of <i>ficate of</i>		id Mental		Reg. No	200	7 0030
Physicia Medical Exami	an/ ner	Decedent's Name (First, Midd Wilma	William William	ns				2. Date of De Month January	ath Day	Year	3 Time of Death 1309 hrs
		4a. Facility Name (if not instituti Mercy Medical Cente	-	er)	4	b. City, Town, o Baltimore	Location of D		4c. (County of Death	1
Funeral Director		5. Social Security Number 142-52-7368	6. Sex 7 A	ige (In yrs Tasi	t birthday) Yrs	If Under 1 Year Months Day		Hrs. 8. Date of 8		D/YYYY) 9 Bir Foreig	thplace (Stale or gn untry) Utah
, any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	on					10d Inside City Limits
Maryland 28a-f show d at once.	tor	MD 10e. Street and Number	N/A	Ba	ltimor						1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	al Director	29 Horserad				10f. Zip Code 212	202		10g. Citize	en of What Cour USA	ntry?
) 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	by Funeral		vorced If Yes, Give Year	5? 2 X No	If Ye	Decedent of His specify Cubar Yes 2 X No	n, Mexican, Pu		S	White, etc.	can Indian, Black,
6 72 hou m "nat	leted	Elementary/Secondary (0-12)			during mo	st of working life	DO NOT use	retired)	16b. Kir	nd of Business/I	ndustry
215-0036 be filed within 72 mal Hygiene rked other than "	Completed	12th 17. Father's Name (First, Middle	2yrs.		State			al Hygien			rious
21215-0036 Uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	Herman	W	lliams			Ann	ie	But1	er	
MD and 2 sho alth and m 27 is	은	19a. Informant's Name/Relations Mary L. Dotso		i i	2406	Loyola	Northw	or Rural Route Nul ay Apt. !	mber, City T1 Ba	or Town, State	Zip Code) e, MD 21215
Baltimore, Department of He Important: If ite		20a Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from S	tate cre	matory or other			Date (0.4007)	1	cation - City or	
Baltimo permit Page Department o Important: injury or oth	1	4 Donation 5 Other S 21. Signature of Funeral Service		Tri		emetery ame and Address		/9/2007 ARCH FUN		ltimore	
	-	Dl adı	o Wa	ner	1 11	OIE N	orth Av	enue Bal	timor	e. MD	21202
Physician /Medical	ļ	23a Part I. Enter the disease, or failure. List only one cause	on each line.			e mode of dying,	such as cardia	ac or respiratory arr	rest. shock	k, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	sequence of):							Deall
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons		otic Cardio	vascular Dis	sease				_
W	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a cons	sequence of).							
evecuted an and al - transit	a E		d								
	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outco	ma of second							
lox 687 leath certific e attending p	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Uni	1 Live birth 4 Pregnant a	it time of death	2 Feta	al death 3	Ectopic pre	gnancy		Date of delivery onth D	ay Year
ires that the displayed by the detached	δ	Part II. Other significant condit	ions contributing to dea	th but not resu	Iting in the un	derlying cause g	jiven in Part I				he cause of death? ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires after death al Director: After this certificate has been as led in by the funeral director, page 2 should I	Completed							24a Was autop perfor 1 V Yes	rmed?		opsy findings available ompletion of cause of
/ital	o Be	25 Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital	ent 2 🗸 ER	2/Outpatient		of Death (Che		Residence		
on of \center of \center of \center of \center of \center of \center or \cent	\vdash	27. Manner of Death 1 ✓ Natural 5 Pend	28a. Date of Inj (Month, Day)		Bb. Time of Inju	ury 28c. Injur	ry at Work?	28d. Describe I			
Division attendurs after death urs after death rall Director:	Certification:	3 Suicide 6 Coul	d not be (Specify)	njury - At home	e, farm, street,	factory, office b	uilding, etc.	28f. Location (\$ or Town, \$		Number or Run	al Route Number. City
Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	edical C	29a Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of exa	amination and/o	death occurre	ed at the time, da	ite and place, a , death occurre	and due to the caused at the time, date	se(s) and mand place,	nanner as stated, and due to the	d cause(s)
F 3 F 3	ž	29b. Signature and trile of certific	A A			29c License			29d. Dat	e signed (Mont	th, Day Year)
m	-	30. Name and address of person	who completed cause of	death (Item 23	a)	O.C.1	И.Е. ————		Janua	ry 2, 2007	
		Mary G. Ripple MD.	Deputy Chief Medi	ical Examir		Penn Street,	Baltimore,	MD 21201			
Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	- A	2	-				
DHMH 17 Rev 1/20		JAN 0 9	2007 SERENA	الگار در	RIGINAL						

	_ 1	State of Maryland / Department - State Registrar State of Maryland / Department Certificate			giene Reg. No. 2007	00310
Physicia	n	1. Decedent's Name (First, Middle, Last) SAMUEL WEINAPPLE		2. Date of Dea Month JAN	Day ZOO7	3. Time of Death 7 · 35P M
/Medica		4a. Fecility Name (If not institution, give street and number) BRIGHTWOOD NURSING CENTER	Town, or Location of Death	LLE		TIMORE
Funeral Director		220-05-55/4 X 101 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth 11/08/1	1905 9. Bin	thplace (State or Foreign puntry) POLAND
Maryland -f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE				10d, fnside City Limits 1 X Yes 2 ☐ No
h with the	al Director	10e. Street and Number 10f. Zip 5715 PARK HEIGHTS AVENUE #911	Code 21215		10g. Citizen of What Co	ountry? USA
re, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mental Hygiene. Item 27 is marked other then "natural", or itams 23a or 28a-1 show other traumatic event, the Mudical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Windowed 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Windowed 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Windowed 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Windowed If Yes, Give Year or Dates:	ent of Hispanic Origin? (Sp rfy Cuban, Mexican, Puerto D No Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036 d within 72 hours at giene. or then "natural", or the Madical Exem	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BARBER	k done during most of work	sing	16b. Kind of Business TONSORIAL	/Industry
yland 212 ould be filed with Mental Hygiene. serked other then setic event, the	To Be Co	17. Father's Name (First, Middle, Last) HYMAN WEINAPPLE	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	KURYK
, Maryland and 2 should be file asith and Mental Hy n 27 is marked oth		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Run APIN ROAD -			
		20a. Method of Disposition 1 💢 Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nam cemetary, crematory or of LIBERTY PARK S	ther place) ZIUN	7/2007	20c. Location - City or RANDALLSTO	
Baltimo permit. Pege Department o Important: if any injury or		Rey Clar Lee 8900 R	d Address of Facility SO EISTERSTOWN	ROAD - 1	PIKESVILLE,	
Physician /Medical Examiner buvisicien and physicien and the purial-transit the purial-transit	dicai Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2a. FAIURE TO T Due to (or as a consequence of): COROWARY AND Due to (or as a consequence of): CANDIOMY OPA Due to (or as a consequence of):	HRIVE LTERY D	15 EAS		Interval Between Onset and Death Conset
Box 6 ath certifi	by Physician/Medica	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown d. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pr 4 ☐ Pregnant at time of death 5 ☐ Other (sp			23d. Date of de Month	blivery Day Year
D hat bd t	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contribution.	ause given in Part I.		obacco use contribute t	to the cause of death? Probably 4 Donknown
Re lay	Completed				rmed? death?	autopsy findings available completion of cause of s 2 \(\sumsymbol{\subset} \) No
Vital Fician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Dea			
ng Phy fler this	ဥ	1 Yes 2 No	OA Other: Nursing H		dence 6 Other (Sp how injury occurred	ecify)
Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Anvestigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	y, office	28f. Location (: City or To	Street and Number or F wn, State)	Rural Route Number,
ne Hospit. 124 hours ne Funera	a	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	in my oninion, death occur	rred at the time	date and place, and du	ie to the cause(s)
To the within To the comp	W	29b. Signature and title of certifier 29c	License number		29d. Date signed (Mor	nth, Day, Year)
6		29b. Signature and title of certifier 29c. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shallwhaa Gupta 9650 50m 31. Date filed (Month, Day, Year) 32. Registrar's Signature	tigo Roc	d Ru	ute 110	(olumbia 14021043
Sta Regist	ite rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

		-	= State Amend #8, perFH,	State of Mar G863, 1/9/07	yland / De TT	epartmei Certifica	nt of H <i>te of L</i>	ealth and N Death	Mental Hy	giene Reg. No.		00011
	Physicia	_	Decedent's Name (First, Middle, Las FRANK) H		WA	TZMA	N	2. Date of De)0 ^Y 7 ^{ar}	3. Time of Death 4;50 A M
9	/Medic Examin	150	4a. Facility Name (If not institution, give					Location of Death		4c. Count	y of Death	
#			8201 16th STREET #				/ER S	PRING		MONT	GOMER	Υ
b	Funeral Director		5. Social Security Number 6. Sec 220-44-2786		n yrs. last birtho	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 02/22/ 2	786 <u>1</u> 907		Diace (State or Foreign TNGTON, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town c	r Location					T	10d. Inside City Limits
	Maryl -f sho lled at	tor	MD MONTGO	MERY	SILVER	SPRIN	à					1 □Yes 2√ No
	h the	Director	10e. Street and Number		· · · ·	10f. Z	p Code			10g. Citizen of	What Cou	ntry?
	23a c		8201 16th STREET #				0910_				S.A.	
	er dez items ner m	Funeral	11. Mantal Status	12. Was Decedent Eve Armed Forces?		13. Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Ha	ce - Americack, White,	etc.
36	within 72 hours after death with the Maryland jene. jene. than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Mes, Give Year or Dates:	WWII	1 ☐ Yes	2 X No	Specify:		Spec	ify:	WHITE
5-0036	72 hou natura iica E	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Us	ual Occup	ation during most of wor	kina	16b. Kind of I	Business/In	dustry
21	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT	use retired	1)	9		LAW	
N	Hyg Ther		17. Father's Name (First, Middle, Last)		<i>γ</i> (1101	VIVL I		18. Mother's Nan	ne (First, Middle	!		
au	و و چ	To Be	CHARLES		WAT	ZMAN		ROSE				BLOCH
Maryland	d 2 should th and Men 7 Is marke traumatic	۲	19a. Informant's Name/Relationship (7	Type. Print)	19b. N	Mailing Addres	s (Street	and Number or Ru	ıral Route Numb	er, City or Tow	n, State, Zij	p Code)
	s 1 and 2 f Health item 27 I		SANFORD L. ROSENB	LOOM/ATTORN				<u>COURT-BAL</u>				
ore	of F filte		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	-	crematory or	ame or other plac	1	Date	20c. Location	•	
altimore,		N	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	-	MT. LEB		and Addre	01/07 ss of Facility	SOL LEV	ADELPH		
Ba	permit. Departr Importa any Inji		Liett M.	Cuttle	1			_				, MD 21208
П			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the one cause on each line.	e death. Do no	t enter the m	de of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Con	gestiv	e He	art	Faili	ire			2 months
1	/Medical Examiner		1	Due to (or as	onsequence of): 	2000	· Faili Disea	20.			Years
		Je.	Sequentially list conditions, if any, leading to homediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of	PIRT	ery	01300				Tenry
1	acuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	icate be executed physician and s the burial-transit		resulting in death, cast	Due to (or as a	consequence of):						
687		edical		-d								
	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf		2 DEstants	programa			23d. D	ate of deliv	very
B	that the death certificed by the attending posterior detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti 9 Unknown		3 □Ectopic 5 □ Other (y		l h	<i>l</i> lonth	Day Year
<u>Р</u>	hat the d by tl letach	Phy	9 ☐ Unknown Part II. Other significant conditions of		not resulting in t	he underlying	cause div	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
Division or Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	d by	Tale in Gallot organization				g		1 🗆	Yes 2 □ No	3 ☐ Pro	bably 4 Donknown
Ö	s beer s beer	Completed							24a. Was		. Were aut	opsy findings available
200	The lay	mo:							auto perf 1⊟ Yes	ormed? 2 No	death?	ompletion of cause of 2 No
/ita	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?				Lau		ath (Check only	one)		
or/	Physic this c al dire	P	1 Yes 2 No 27. Manger of Death	Hospital: 1 ☐ Inpatient	2 ER/Outp			4 LI Nursing F	tome 5 Res	idence 6 🗆C		ify)
Ou	Attending Physician: r death. ector: After this certific by the funeral director,	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		ury M	28c. Inju Wor 1 🗌	k? Yes 2 □ No	Zod. Describe	now injury occ	uneu	
Visi	Atten r deat ector: by the	Certification:	3 Suicide 6 Could not be determined		y - At home, farr (Specify)	n, street, fact	ory, office		28f. Location	(Street and Nur own, State)	nber or Ru	ral Route Number,
Ö	Ital or rs afte ral Dir	Cert										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical		ysician: To the best of niner: On the basis of e and manner state	examination and							
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	_		2		se number		29d. Date sign	ned (Month	, Day, Year)
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		> play	10			5.	2069		1-	É -	07
	L		30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	ype, Print)	А	_ 4	, 200	5/	- 0-	ring MD 20902
	12		31. Date filed (Month, Day, Year)	MD /	03/3 (seorgi	141	i Suil	2 50/	, silve	الراد	20903
	St Regist	ate rar		007	, 11.	Spack	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g63 1-9 0/ vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Of Month **Physician** 129. Walker 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min. Director 217 22 8397 apr.9,1928 MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f sh must be notified 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 HAMILTON AVE. Items 23a 21214 Funeral usa Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Marian Yes 2 □ No Black, White, etc. other traumatic event, the Medical Examiner 72 hours after Yes 2 The Yes, Give Year or Dates: 1X Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify. 2 Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12TH POLE TECHNICIAN TELEPHONE CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY LEE WALKER ပ MARIHA JACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANETTE WALKER (GREAT NIECE) 2810 HAMILTON AVE. BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from \$tate GARRISONETERANTCEMJAN.12, 2007OWINGS MILLS,MD. Monation 5 ☐ Other (Specify) nature of Funeral Service License 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) 21212 Approximate Interval Between Onset and Death Immediate Cause (Final ShOCE se **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transif and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death Fetal dear 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 2 No 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MacUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO

Registrar
DHMH 17 Rev 1/2001

State

E.SABAEVA; GOOD SAMARITAN HOSPITAL, BEOI LOCH RAVEN BOULEVARD, BALTIMOR, MD

21239 2995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 JAN 0 9 2007

32. Registrar

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State	of Maryland / I		artment of H rtificate of L		ind Me		ene g. No:	07	003	13
	Dhysio	0.0	1. Decedent's Name (First, Middle	_					2	Date of Death Month	Day	Year	3. Time of	
	Physici /Medic			Worsley						01	06	2007	4:30	РМ
	Examin	er	4a. Facility Name (If not institution Futurecare - Sand				4b. City, Town, or	Location of timore.			4c. Cou	inty of Death		
	- Francis	04 N	Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 2	24 Hrs. 8	. Date of Birth		9. Birthp	lace (State o	or Foreign
	Funeral Director		237-20-9867	1 □ M 2 🔏 F	91		Months Days	Hours	Min.	(Month, Day, 7/09/1915		Cour	MD	
	P .		Usual Residence of Decedent		100 City To								0d. Inside Ci	ity Limite
	show	2	MD 10b. County		10c. City, Tow		Baltimore						1 X Yes	•
	the M	Director	10e. Street and Number			-	10f. Zip Code			10	la. Citizen	of What Cour	itry?	
	3a or		229 North Mount S	treet				223				JSA	,	
	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or fleme 23a or 28a-f show ent, the Madical Exeminer must be natilised at	Funerai	11. Marital Status	12. Was Dec Armed F	cedent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	gin? (Specif	ty Yes or No-	14. [Race - Americ Black, White,		
9	or ite	E.	1 Never Married 2 Marr	ied 1 ☐ Yes	2 No		1 ☐ Yes 2 🕱 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Juli, 010.7				
ë	urel',	d by	3 Widowed 4 ☐ Divorced			Door	dent's Usual Occupa	ation		1		Africated Business/Inc		can
5	in 72	Completed	(Specify only highes	st grade completed)	(Give	kind of work done of DO NOT use retired	lurina most	of working	· '	ob. Kina o		austry .	
272	with a state of the state of th	mo;	Elementary/Secondary (0-12) unknown	College	(1-4or 5+)		unknown				υ	nknown		
Maryland 21215-0036	al Hyg	Bec	17. Father's Name (First, Middle,					18. Mother	r's Name (A	First, Middle, M		name)		
<u> </u>	should be tand Mental Is marked o	P _C		unknown						unkn				
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relations				ng Address (Street a						Code)	
	1 and 2 Health sem 27 l		Sherna Barksdale .	/ Guardian	20b. Place of	of Dispo	Calvert Str		altımor Dat			1201 on - City or To	own, State	
nor	Pages nent of I ant: if it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		i State	* .	natory or other place. Cemetery		1/10/20	007 82	1timor	e, Mary	land	
Baltimore,	# 원원 중		21. Signature of Funeral Service				2. Name and Addres	s of Facility	y Wyli	e Funera	1 Home	. P.A.		
m	Depar Impo		Jemela	. Jone	2		638 N. Gil	mor Str	reet; E	Baltimore	, Mary	land 21	217	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death. Do each line.	not en	er the mode of dying	g, such as o	cardiac or r	espiratory arre	st,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	_a. D	ehyde	CA	tion						Onset and i	Deam
	/Medical Examiner		resulting in death)	Due to	(or as a consequence	of): '	e.J							
-13.		<u>ا</u>	S quentially list conditions,	b. Due to	O (or as a consequence	off:								
ph	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	K		,	4100							
o Î	exect an and rial-tra	Exa	resulting in death) Last	C. Due to	(or - a consequence	of):	•							
8760,	cate be executed physician and the burial-transit	dicai		d										
39 X	e as s	Med	IF FEMALE:	00-16							1	•		
.O. Box	The law requires that the death certificate be executed ate bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregnancy birth 2 □ Fetal deati gnant at time of death nown		Ectopic pregnancy Other (specify)				23d.	Date of delive Month	,	Year
<u>q</u>	that the	Ph)	Part II. Other significant condition	ons contributing to	death but not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use c	contribute to the	ne cause of c	death?
ds,	uires Isign Ild be									1 🗌 Ye	s 2 🗆 N	o 3 Prob	ably 4 🖫	onknown
Vital Record	s beer s shou	Completed								24a. Was an		4b. Were auto	psy findings	available
æ	The la	mo:								autopsy perform 1 Yes 2		death?	mpletion of c 2□ No	ause or
ital	stan: ertifice ctor, g	Be C	25. Was case referred to medica examiner?					26. Place	of Death	Check only one)			
of V	Physician: r this certific ral director,	၉	1 Yes 2 No		Inpatient 2 ER/O	<u> </u>		445 1401		5 Resider			y)	
no On	ling P	i o	27. Manner of Death 1 ☐ Matural 5 ☐ Pendir	ng (Mo	e of Injury nth, Day Year) 28b.	Time o	Worl	/at k? Yes 2∐1		d. Describe ho	w injury oc	curred		
Division	or Attending Physician: The larafter death. Director: Atter this certificate has in by the funeral director, page 2	licat	2 Accident investi 3 Suicide 6 Could	not be	e of Injury - At home, f	arm. st				f. Location (Str	eet and No	umber or Rura	I Route Num	nber,
<u>S</u>	after after Dire	Certification:	4 Homicide determ	buil	ding, etc. (Specify)		,,,			City or Town,	, State)			
	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai C	(Check only 2 Medical	Examiner: On the	ne best of my knowledg basis of examination a	e, deat	h occurred at the time extigation, in my of	ne, date and pinion, deat	d place, and	d due to the ca at the time, da	use(s) and ite and pla	d manner as s ce, and due to	tated.	5)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifie		nner stated.		29c. License	e number		29	d. Date sig	gned (Month,	Day, Year)	
	F 3 F ŏ		Jamel (lbica				167-	48		118	107		
_	4		30 Name and address of person	201 4	414 12,	(Type	LS RD	B	AL	10 1	20	2121	1	
26 24	Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Signature	bon	U							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:55 P M Willner January evov 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death lhmore University of N/A Maryland Medical Cen 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 18, 1 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last b 1**X** M 2□ F Months Days Hours Maryland 90 Ĩ916 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes 2 X No Parkville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd Apt 2412 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. l [v] Yes 2 □ No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Welder 12 US Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Willner Annie Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Willner-Wife 8810 Walther Blvd Apt 2412 Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/9/07 Baltimore, MD 22 Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 23a. Part 1. Enter the disea shock, or heart failure se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Hortic Stenos disease or condition resulting in death) Due to (or as a consequence of) linguary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Ex miner must be notified at

filed within 72 hours after of Hygiene.

ב should be fi ו and Mental H

"natural",

is marked other than

Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I

Physician

Examiner

burial-transi and

nding physician ause as the burial

detached

signed by t

been si should

page 2

funeral (

this certificate

After

/Medical

the Medical

Baltimore, Maryland 21215-0036

Director

Funeral

δ

Completed

Be ပ္

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one) 29b. Signature and title determined

of certifier

SINA

CARTICHONALIC

death certificate be executed Division or Vital Records, Hospitai or

ours after death.

neral Director: A
filled in by the fu To the Hospital within 24 hours a To the Funeral I

State

Registrar

DHMH 17 Rev 1/2001

lame and address of person who completed cause of death (Item 23a) (Type, Print)

SMUERLY

South 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month 2007 1:20 PM Physician CLA January wathea /Medical 4a. Facility Name (If not institution, give street and number)
Relaced Park Place, 830 W-40 th St 4c. County of Death 4b. City, Town, or Location of Death Examiner Balfunare Cit Balkeauere, Rd 21211 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace Country) State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 90 124-09-4858 10/17/1916 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21212 USA 7321 Brightside Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐ Yes 2 No 1 Never Married 2 Married 1□ Yes 21 No Specify: White Specify: If Yes, Give Year or Dates: þ 3 □ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Newspaper Elementary/Secondary (0-12) College (1-4or 5+) Journalist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Harry Tipper Mattison ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Apgar/Daughter in law 7321 Brightside Road Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
any injury or otl Jan 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesipeake Crematory Inc. 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final atherosclaratic cerebro wasenlar ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Roulivre Chrome renal 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place eath Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 No Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28d. Describe how injury occurred 28b. Time of 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

the Maryland

filed within 72 hours after deeth

Baltimore, Maryland 21215-0036

ral', or iteme 23a or 28e-f ehow Examiner must be notified at

"natural",

other

Is marked

Health Item 27 I

Mental

Pages 1 and 2 should be

burial-transit : After this certifice funeral director, t r death. seral Director: A filled in by the fi within 24 hours after d To the Funeral Direct completely filled in by To the

> h State

Registrar

Medical

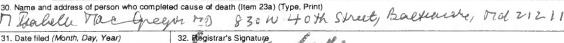
31. Date filed (Month, Day, Year) JAN 1 0

Do wahelle Tac

29b. Signature and title of certifier

29a. Certifier

(Check only one)



Selve

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

013657

29d. Date signed (Month, Day, Year)

January 5, 2007

07-00198 Jayme Annis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Time of Death Physician/ 1556 hrs Medical Examiner Jayme Keith Annis January 7, 2007 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arunde Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24Hrs **Funeral** Months Days Hours 217-71-0987 Director Jan. 8, 2005 1 X M 2 1 Country)Maryland Yrs Usual Residence of Decedent 10d Inside City Limits 10c City Town or Location 'n 10a State Yes 2 X No 23a or 28a-f show notified at once. Glen Burnie Maryland Anne Arundel after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 95 Mary Lane, Apt. 303 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral Was Decedent Ever in U.S 14. Race - American Indian, Black must be Armed Forces? White etc 1 X Never Married 2 Married 2 X No Yes White f Yes. Give Yea Specify: Widowed 1 Yes 2 X No specify: Divorced ⋧ 16b. Kind of Business/Industry ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Baltimore, MD 21215-0036 O N/AN/A18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennifer Marie Lien Jayme Keith Annis, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer M. Annis / Mother 95 Mary Ln., Apt. 303, Glen Burnie, MD Important: If item 27 i injury or other trauma 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) January X Burial 2 Cremation 3 Pages 1 Removal from State 12, 2007 Glen Burnie, Maryland Glen Haven Mem. Pk. Donation 5 Other Specify 22 Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., L Funera ervice Licer Funeral Home, P.A. S.E., Glen Burnie, Crain Hwy., 21061 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Acute upper respiratory infection Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Hypoxic brain injury Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause Placental abruption (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last cian/Medical X UNPENDED 27. perME. Box 68760, 23d. Date of delivery IF FEMALE phys the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Physic Yes 2 No 9 Unknown be detached 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? 2 No ✓ Yes 2 1 🗸 Yes After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: funeral director, Be Hospital: 1 Other₄ DOA Inpatient 2 CR/Outpatient 3 Nursing Home 5 Residence 6 Other ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 the Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Funeral (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. January 8, 2007 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

			For	State of Mary					dental Hy	giene		
			State Registrar		Cei	rtificate	e of De	ath	1	Reg. No	007	-0.0317
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Harry McCain 4a. Facility Name (If not institution, give		- 1	4h City T	Town or Loc	ation of Death	Janu		8, 200 county of Deat	
	Examir	ier	- 1010	wate Hos	wital	40.04	2056	dale			Balt	-imone
	Funeral		5. Social Security Number 6/S	ex 7. Age (II	yrs. last birthday)	If Under Months		Under 24 Hrs. lours Min.	8. Date of Bir	th av Year)	9. Birt	hplace (State or Foreign
Ь	Director		215-56-4322	XM 2□F 5	Yrs.	Months	Days n	ours Min.	8. Date of Bir (Month, Da July 5,	1948	Flo	orida
	p *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation						10d. Inside City Limits
	// Aaryk feho	6	Maryland Harfor	d	•	Ed	lgewood	d				1 ☐ Yes 2 X No
	r 28a-	Directo	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip				10g. Citize	en of What Co	ountry?
7	h with	a D	1722 Harbinger 7	rail			21	040		и.	.s.A.	
	ema (Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decede	lent of Hispar	nic Origin? (Sp lexican, Puerto	pecify Yes or No Rican, etc.))- 14	4. Race - Ame Black, Whit	
36	s afte	by Ft	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 X Yes 2 □ No. If Yes, Give V. Year or Dates: En	etnam	1 ☐ Yes 2	2⊠ No S	pecify:		S	Specify: (Ihite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ehow ta Medical Evantical must be notified at	ed b	15. Decedent's E	L/L	16a. Dece	dent's Usua	il Occupation	1 .		16b. Kind	d of Business	Industry
215	nin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)				ig most of worl				
N	filed will Hygiene ther the	Som		Ĩ	Senio)	r Syst		nginee		1	re Fir	st
<u>a</u>	be filed within 72 hours after death with the Marylan tiel Hygiene. Id other than "natural; or itema 23a or 28a-f show avent, the Medical Evantiner must be notified at	Be	17. Father's Name (First, Middle, Last,	_				Mother's Nam hyllis	ne (First, Middle	, Maiden S Vasmus		
Maryland	2 should be filed within and Mentel Hygiene. Is marked other than aumatic avent, Ita M	10	Francis Louie 19a. Informant's Name/Relationship (Bates	10h Maili	na Address			ral Route Numb			Zin Code)
Na Na	2 6 5 6		Mrs. Linda Bates				-		Edgewoo			
<u>6</u>	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, crea	osition (Nam	ne of ther place)		Date	20c. Loca	ation - City or	Town, State
Ë	8 = 5		1 ☐ Burial 2 🛱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Bayview (-		1/12/	/2007	Balt	imore,	Maryland
Baltimore,	Department Department Mportant: Iny injury		21. Signature of Funeral Service Lices	1588	i				himunek	-		
_	88 5 8		E pront						Baltimo)		0 21236	
			23a Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	e death. Do not en	ter the mode	e of dying, su	uch as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Caroli	ogeni	C .	Sho	CK				
	Examiner			Due to (or as a c	onsequence of):	art	- Ic	Silver	20			
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or)as a c	onsequence of):	2001	1	711001	1		1	
	ete be executed hysician and the burial-transit	Examiner	that initiated events	· Acut	e Res	biro	itor	4 DIS	stress	Siny	drop	16
0,	law requires that the death certificete be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					J		
8760,	cete b	Physician/Medical	•	d								
9 X	leath certifice attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					23	3d. Date of de	livery
Вох	that the death cert ed by the attendin detached for use	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pro □ Other (spe					Month	Day Year
P.O.	t the d by the achec	hysi	9 Unknown	9□ Unknown								
ď.	signed I		Part II. Other significant conditions	contributing to death but r	not resulting in the u	underlying ca	ause given ir	n Part I.				the cause of death?
Records,	v requires been sign should be	Completed by	bronchagen	10 car	einon	ria			1)2	Yes 2	No 3∏P	robably 4 □Unknown
ecc	has be	npie							24a. Wa auto	DSV	24b. Were a	utopsy findings available completion of cause of
Ξ Ξ	: The	ပ်							1 ☐ Yes	ormed? 2 X No	death? 1 ☐ Yes	2 □ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Other		ath (Check only			
ð	Phys rthis raldii	5	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 Ninpatient 28a. Date of Injury	2 ER/Outpatie		28c. Injury at Work?	4 ☐ Nursing H	lome 5 Res			ocify)
O	ding th: Afte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury	м		2 🗆 No				
Division	Attended of the py the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (treet, factory	, office			(Street and	Number or R	ural Route Number,
Ö	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page											
	Hosp 4 hou Fune (ely fil	Medicai	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of ex	camination and/or in	th occurred nvestigation,	at the time, of the control of the c	date and place on, death occu	, and due to the irred at the time	e cause(s) a , date and p	and manner a place, and du	s stated. e to the cause(s)
	o tha ithin 2 o the emplet	Med	29b. Signature and title of certifier	and manner state	<u>.</u>	290	c. License nu	ımber		29d. Date	signed (Mon	th, Day, Year)
	F ≯ F 8		Man 4				RES	000	00	Jan	110100	V 2007
1	511		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type	, Print)		-10 0	11	$-\alpha r$	nary	2001
1	7		DR May yen	9000 Fran	Klin Sa	war	e Dr	ine L	salt im	ove	Ma	41237
	St	ate	31. Date filed (Month) Day, Year)	32. Redistrar's	Signature	A - 20	0)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 20 3 2007 Janua Flossie 4c. County of Death NIA 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number are Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🖫 F Yrs. Jan 19 1920 86 213-28-6851 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □ Yes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 21209 USA 4800 lowood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 140 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Brick 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domesti C 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) lartha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State Fernhill 4304 Auce Newman lartha 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-9-07 Pioce 22. Name and Address of Facility Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeval Service Licensee Betts Fineral Balto, MD 21213 1129 N- Cavoline St 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) One to (or as a consequence of): Exmouly Mostry Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Onknown sean 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Gypertin &

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

à

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumetic event, "In Medical Examinal mout be retitlied at

Baltimore, Maryland 21215-0020

Physician/Medical Examiner attending physician and for use as the burial-transit been signed by the should be deteched þ this certificate has been si ral director, page 2 should Completed To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. Be edical Certification: To

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24No 1 Tyes

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25.	Was case		to	medical
	examiner?			
	1 1 162	2 MO		

3 Suicide

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Techniques Physician: To the best of my kin whargs, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number MD D 31464 29d. Date signed (Month, Day, Year)

MD, &ZIN, ENTAW ST Smite 308, BALTIMORE MU 2121 .HASHMI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MANN

Registrar

State

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Day Wilson Bergamyer 8, 2007 Roland 6:45AM M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 9104 Fairgreen Ct. Upper Marlboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Ochlorth, Pay, Year) 18 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√M 2□F 88 Yrs. Director Sharonville Ohio 302-05-4046 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director Maryland Prince George's Upper Marlboro 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or ? U.S.A. 20772 9104 Fairgreen Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1941 − If Yes, Give Year or Dates: 1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐No WHite Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. <u> Government</u> <u>Retired Military</u> permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bergamyer Lizzie Mav Malott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9104 Fairgreen Ct. Upper Marlboro, Maryland 20772 Maria M. Bergamyer (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington National Cem. 2007 Arlington 21. Signature of Funeral Sarvice Lidensee Lee Funeral Tome. Inc. 22. Name and Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD 20735 rans 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** accide 10 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical physi the b as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2►No 24a. Was an performed? page 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural (Month, Day Year) Injury 5 ☐ Pending s after death. 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a the Hospital Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Hanson Ct. Bowie 4175 Dobin 32 Registrar's Signature William . Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle/DLast) Month **Physician** 200 /Medical 4a. Facility Name_(If not ipetitution, give sti Examiner 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9 / 0 4 / 1 9 2 5 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number **Funeral** Months Days Hours 81 MARYLAND Director 214 22 9599 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is marked other than "naturel" or items 23a or 28a-f show any injury or other traumatic event. the Medical Eventant. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8433 COCO ROAD 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No Black, White, etc. 1X Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes Ž No WHITE Baltimore, Maryland 21215-0036 Specify. Specify: ΙI ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLANT MANAGER BP OIL 11 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELWOOD J. BECKER SR. BECKER ANNA Μ. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8433 COCO ROAD FRANCES J. BECKER/ WIFE BALTIMORE, MD 21237 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) OAK LAWN CEMETERY 3 ☐ Removal from State 1/12/07 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Lice 1211 CHESACO AVENUE BALTIMORE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator) arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-tran the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown cate has been signed by page 2 should be detact death but not respliting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy ase referred to medical the Hospital or Attending Physician: hin 24 hours after death. funeral director, 26. Place of Death (Check only one) Be 2 Other: 4 Nursing Home 5 sidence 6 Other (Specify) Hospital: 1 Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and add

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

gistrar's Signature

DHMH 17 Rev 1/2001

		•	State of Maryland / Department of Hea 1 - State Registrar		lental Hygier	2007	00322	
			Decedent's Name (First, Middle, Last)				3. Time of Death	
	Physicia		Sulvia Bridgewater		2. Date of Death Month	Day 5 2007	13:56 PM	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of Death		
			University of mayland Medical Center Baltim	none		nla		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hi	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye OCt. 09 1	9. Birth	olace (State or Foreign	
	Director		213-02-4820 1 M 2 X F 54 Yrs. Months Days House State		Oct. 09 1	952 West	Africa	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if tiam 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Mardical Examination unit be invitiled at once.		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
			Maryland Anne Arundel Pasa	adena			1 ☐ Yes 2 No	
		Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	ntry?	
		ai	8104 Foxberry Lane Apt. 1418	21122		USA		
		Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispar If Yes, specify Cuban, M	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.		
36		by Ft		1 ☐ Yes 2 ☒ No Specify:		Specify: Black		
215		To Be Completed	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16h			
			(Specify only highest grade completed) (Give kind of work done during life, DO NOT use retired)	ing most of worki	ing		,	
			Elementary/Secondary (0-12) College (1-4or 5+) Minister			Religio	n	
ם			17. Father's Name (First, Middle, Last) 18.	3. Mother's Name	(First, Middle, Maid	den Sumame)		
<u>a</u>			Kojo Acquah	Elizabe	eth Er	nchia		
ā			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and It as Seventhal Control of the Seventh					
			Lafayette G. Williams (spouse) 8104 Foxberry L 20a. Method of Disposition (Name of	, ,	Onto DO-	'asadena, . Location - City or Ti		
٥			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Jan.	19	,		
altimore,			'4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem 2006 Crownsville Maryland 21. Signatur of Funeral Service License / 22. Name and Address of Facility Stallings Funeral Home D. A.					
Ba			21. Signature of Funeral Service License Licen					
	cate be executed hypotecian and hypotecian and cate principles and the purial-transit the burial-transit	iner	23a. Part I. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line	such as cardiac	or respiratory arrest,	ina, IID EI	Approximate Interval Between	
			Immediate Cause (Finat disease or condition					
			resulting in death) a Due to (or as a consequence of):					
0			Sequentially list conditions, b.					
11			if any, leading to immediate Due to (or as a consequence or):					
X		Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	(or as a consequence of):			-	
8760, 🛪		dicai E						
687	ificate g phy as the	0	· ·				76	
Вох	edeath certific he attending p ed for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			23d. Date of delivery Month Day Year		
B		Physician/M						
P.O.	that the de ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I	23e Did tohace	co use contribute to t	he cause of death?	
of Vital	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	l by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown		
		etec			24a. Was an	24h Were autr	opsy findings available	
		Completed			autopsy performed	prior to co	mpletion of cause of	
		e C	1 Yes 2 No 1 Yes 2 No No Yes 2 No Yes 2 No Yes 2 No Yes					
		0 B	examiner? 1 Yes 2 No					
		n: T	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		28d. Describe how injury occurred			
		Certification:	2 Accident investigation M 1 Yes	M 1 ☐ Yes 2 ☐ No At home, farm, street, factory, office 28f. L				
Σ		riff	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			Location (Street and Number or Rural Route Number, City or Town, State)		
		edical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
			(Check only one) Chief only one Chief one C					
	To the within To the	Me	29b. Signature and title of certifier 29c. License nu	umber	29d.	Date signed (Month,	Day, Year)	
	,		bennis mo Pallay	1	2	an &	2007	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	_	,		-	
			Aimer Bennis 22 South Green Street.	Balt	timere r	MD 318	101	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	negisti	ul .	JAN 1 0 2007 Com S.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#2, perbvk, G803, 1/11/07, WS

Amend Items 23a Pt 1,11 per dr. G864,02/09/07dhb

Reg. No.-Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** BAILEY JANAACY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AKE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**⊠**M 2□F 216-32-8429 Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other treumatic event, the Madical Examiner rust be notified at Md. 1X Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? ò U. S.A. or Items 23a APT. 4-K 15/0 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any Injury or other treumatic event, Ite Mad Elementary/Secondary (0-12) College (1-4or 5+) 12% UNEMPLOYED NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BAILEY KOPENSON JOHN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLEAM BASLEY BROTHER BALTO., Md. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10107 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License romailie 2700 Ednardson Av 23a Fant. Enter the disease, or complications that caused the death. Do not ofter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acquired Immunodeficiency Syndrone Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a c Cerebral vascular accident **Examiner** neutension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consp Examine burial-transit Hypertension attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical Seizure as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Progressive Decline Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 🗌 Yes 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1,09,2007 address of person who completed cause of death (Item 23a) (Type, Print) Entant of # 308 Baltimme MP21201 Mohamed lassin 821 N 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 0 2007 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Kashyia Ivyaina Colleton 6 2007 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUPKINS Johns If Unde Hours Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**XX**F Min. N/A Director 2007 6 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show iral", or Items 23a or 28a-f shov Examiner must be notifled at 1,∏Yes 2 No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Elmley Avenue 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Black 3 Widowed 4 Divorced nem 27 is marked other than "natural", other traumatic event, the Medical Exa Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of Derrick Colleton Valarian ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valarian Anderson-mother 3300 Elmley Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If Its any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial PArk 1/12/2007 Randallstown MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME-EAST adra an 1101 E. North Avenue Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Extreme Prematurity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a use Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine use as the burial-tran and Due to (or as a consequence of) Box 68760. attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) P.O. I signed by the at 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 2 No 1 ☐Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 □ Yes 2 □ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier f 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar the

0

Dur

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

600 North Walte St Baffineree

COLDWELL

NAME KNOWN TO PHYSICIAN: WALTER

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. the Hospitel or Attending Physician;

State of Maryland / Department of Health and Mental Hygiene [] []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Walter F. Coldwell JANUARY 02, 2007 08:55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM PERRY POINT 8. Date of Birth (Month, Day, Dec 8, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days Hours Months 1 X M 2 □ F 138-24-5237 76 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a 23a or 28e-f ehow 1 ☐ Yes 2 ☑ No Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Sandy Hill Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1. Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Iteme 11. Marital Status The Medical Examiner: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed by 49-60 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) handyman unk permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygier Important: If item 27 is marked other 1 eny injury or other traumatic event, ILLS ODG. 12 0 repairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helmi Rantio ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA Maryland Health Care System Bldg 23 Perry Point, MD 21902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation S ☐ Other (Specify) 21. Signature of Euneral Serv. Rona La State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESOPHAGEAL CANCER disease or condition resulting in death) UNKNOWN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4♥ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After th 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. М 1 Tes 2 No 2 Accident investigation tor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct δ within 24 hours after To the Funeral Direct 4 Homicide filled in 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) xernolo france? D42800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS BIONDO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 0 2007

1 - For Stata Ragistrar

Certificate of Death

00326

			Ragistrar			Cert	ilicale of t	Jeani			Reg. No	D.		
	Physici	an	Decedent's Name (First, Middle, Last) Joann				Cope1a	and		2. Date of D Jan 7	eath 200	Yea	3.6	3. Time of Death 22:39 M
	/Medic Examir		4a. Facility Name (If not institution, give street a	and number)			4b. City, Town, or		of Death	Juli 7		c. County of D		
	LAMIIII	ıcı	Southern Maryland		tal			inton				rince		rge's
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 3		e (In yrs. last birth		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of B	inth 19	40 9.1	Birthplac Country	ce (State or Foreign n Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation						10d	. Inside City Limits
	Maryla f eho	ō	Maryland Prince Georg	10			Marlboro	`					100	1 ☐ Yes 2 ☑ No
	r 28a	rec	10e. Street and Number	,,,,	ОР	PCI	10f. Zip Code	,			10g. Ci	itizen of What	Country	
	th with	aiD	9902 Varus Place				20772	2			Uni	ited St	ates	5
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mantal Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ADDS.	Completed by Funeral Director	1 ☐ Never Married 2 📉 Married 1 ☐	s Decedent I ned Forces? Yes 2 1		1	as Decedent of Hi Yes, specify Cuba		gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W		
003	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Ye	es, Give TX 2 ar or Dates:		''	TIES ZATIVO	Specify:				Specify:		Black
Maryland 21215-0036	"nati	iete	15. Decedent's Education (Specify only highest grade comp	leted)		(Give k	ont's Usual Occupa ind of work done of O NOT use retired	during mos	t of workii	ng	16b. F	Kind of Busine	ss/Indus	stry
12	withis iene. than	d LLo	Elementary/Secondary (0-12) Co.	llege (1-4or 5	+)		are Provi				Se	lf- Da	v Ca	are Provid
9	Hygi other	Be C	17. Father's Name (First, Middle, Last)		1 20	<i>1</i> y c c	110 11001		er's Name	(First, Middl			y Ce	ile llovid
ılar	Aenta Menta	ToB	Cromwell Burg	ess				I	Perry	Lee I	andr	rum		
lary	and h		19a. Informant's Name/Relationship (Type, Pri				Address (Street a							
Σ,	and and and and and and and and and and		Franklin D. Copeland	l (hust	Contract of the Contract of th		Varus F	'lace	, Upp	oer Mai	lbor	ro, MD	2077	72
Baltimore,	ges 1 t of H if Itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	I from State		, crema	story or other plac			ate		ocation - City		, State
턡	t. Partmen		4 □Donation 5 □ Other (Specify)		Resurre		on Cemet							
Bal	Depermine Dependent of the poores of the poo		21. Signature of Funeral Service Licensee	lo r	nnigoil		Name and Addres							
			23a. Part1. Enter the disease, or complications	that caused	noiz84		lexandri					on, MD		0735 pproximate
	Dhusisian		snock, or neart failure. List only one caus	se on each iir	θ.								In	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)		a consequence of		MAL IN	FARC	Tion	J				
	Examiner				2 0011024001100 0	.,.							i	
	₽ #	iner	cause. Enter Underlying	Duo to (or as o	l consequence of	fj.		-						
י ל	ecute and -trans	Examiner	that initiated events											
60,	be ex icien a burial			oue to (or as a	a consequence of	r): 								
ox 68760,	es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	n/Medicai	d											
×	certil Iding Ise a	/Me	IF FEMALE: 23c. If v	es, outcome	of pregnancy							00d D-1		
$\mathbf{\omega}$	atten for u		in the past 12 months?	Live birth	2 Fetal death time of death	3 🗆 E	ctopic pregnancy Other (specify)					23d. Date of o Month	delivery Da	y Year
P.O.	The law requires that the deal ate has been signed by the att page 2 should be detached to	Physicia		Unknown	timo or dodan	301	Julei (specify)							
	s that	by P	Part II. Other significant conditions contributing	ig to death bu	it not resulting in	the und	lerlying cause give	n in Part I.		23e. Did	tobacco	use contribute	to the c	cause of death?
Division of Vital Records,	w requires been sign should be	ed b	BREAST CANCER							1 🗆	Yes 2	□No 3□	Probabl	y 4 Donknown
900	aw re	Completed	DIABETES							24a. Wa:		24b. Were	autopsy	findings available
Ä	The I	E								auto perf 1 ☐ Yes	ormed?	death	o compl ? es 2[etion of cause of
ţ	stan: artifica ctor, I	Bec	25. Was case referred to medical examiner?					26. Place	of Death	Check only	- 0.		03 <u>E</u> C	110
>	nysic nis ce	2	1 ■ Yes 2 No Hospital	1 🗌 Inpatie	nt 2 ER/Outp	patient	3□ DOA Othe	r: 4 □ Nui	rsing Hom	ne 5 🗆 Res	idence	6 □Other (S	pecify)	
0	Attending Physician: Ir death. actor: After this certific. by the funeral director, I		27. Mannes of Death 28a. 1 ☑Natural 5 ☑ Pending	Date of Injur (Month, Day	y 28b. Tii Ye <i>ar)</i> Inj	me of ury	28c. Injury Work	at ?		8d. Describe				
sio	tends eath. tor: A the fu	cati	2 Accident investigation				M 1 🗆 Y	'es 2 □ N						
Ξ	or At ifter d Direct in by	Certification;	4 Homicide determined 28e.	Place of Inju building, etc	ry - At home, farr . (Specify)	n, stree	t, factory, office		2	8f. Location City or To	Street ar wn, State	nd Number or a)	Rural R	oute Number,
	pital ours a eral (29a. Certifier 1 Certifying Physician:	To the best of	f my kanyladaa	do o the o			4-1		/			
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only Z Medical Examiner: Or	tne basis of d manner sta	examination and	or inve	stigation, in my op	e, date and inion, deat	n place, a th occurre	nd due to the	date and) and manner d place, and d	as state	d. e cause(s)
	To th within Fo th compi	Me	29b. Signature and title of certifier				29c. License	number			29d. Da	te signed (Mo	nth, Day	/, Year)
			JOD RIE				D 403	24			JAN	WARY !	8,5	1007
		1	30. Name and ddress of person who complete						-	4 10557				F: ====================================
	7		TERRY JODRIE, M.D.	453				LINT	on, n	MARYLI	AND	20-	731	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	loon	Ph. 3							
	Registr	al	JAN I 0 2007	Section Section	-	N. Carrier								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN. MILDRED VIRGINIA DAVENPORT 6 2007 4:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKLINWOODS N. H. ROSSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) May 28, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1□M XX F Months Days Hours 89 218~22~3709 VTRGŤNIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County ir then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No BALTIMORE CITY MARYLAND BALTIMORE CITY Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21206 6609 Moyer Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify Completed by 3¥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other then Hygiene Office Clerk N.A.C. filed 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Arthur James Thorne Mattie Elizabeth Lampkin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: if item 27 ts
any injury or other treu James Wendell Davenport (Son) 6609 Moyer Avenue Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemi 1-10-07 Baltimore, Md. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ²² Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final wherehow Physician Muscardial disease or condition resulting in death) /Medical Due to () as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury as a consequence of): Examiner be executed -transit and that initiated events resulting in death) Last Due to (or as a consequence of). burial-Records, P.O. Box 68760. Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year ö 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 No Division of Vital Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 20 No Other: 1 Tyes 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural Injury or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m D 553462 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Definood Road Glen Burnie MD 21061 7845 Jude Muneres on D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Brenjor (M.) dre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 0 0 3 2 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Dorothy Lucille Davis 01 7:50 P M 052007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15 Scottsbury Germantown Montgomery 7. Age (In yrs. last birthday Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗙 F 218-16-0760 82 5-3-1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 15 Scottsbury Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. white 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetician Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Stanley Burroughs Mattie Mae Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Scottsbury Ct. Germantown, MD 20876 Wanda Lee Brooks/daughter 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 1-9-2007 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO135 Rapp Funeral & Cremation Svc933 Gist Ave20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Year death? Unknown available

Physician /Medical **Examiner**

Physician

/Medical

Funeral Director

Completed by

Be

Examiner

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and Mental Hygiene.

Is marked other than

Health

Department of Important: If it any Injury or o once.

Baltimore, Maryland 21215-0036

item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal themost Medical Certification s after dea....al Director: After

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Shen, MD 501 Frederick Ave. Gaithersburg, MD

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

	disease or condition	Dementia	
	resulting in death)	Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of injury	b	
ICAI EVAI	that initiated events ' resulting in death) Last	c Due to (or as a consequence of);	
I sicial l'Inea	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Yea
ieu ny ri	Congestive Heart		23e. Did tobacco use contribute to the cause of deat
	Chronic Atrial I	Fibrillation	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
U	25. Was case referred to medical	26. Place of Death	
2	examiner? 1 ☐ Yes 2 No		me 5 Residence 6 Other (Specify)
alloll.	27. Manner of Death 1 Autural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury 28c. Injury at Work? Injury M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	3 Suicide 6 Could not 4 Homicide determine	be de 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)
200	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place, aminer: On the basis of examination and/or investigation, in my opinion, death occurrant manner stated.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

State Registrar

29c. License number

D0050209

29d. Date signed (Month, Day, Year)

1-8-2007

07-00029 Almeda Dodd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month **Medical Examiner** 0110 hrs January 2, 2007 ALMEDA DODD
4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death N/A Union Memorial Hospital Baltimore 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9 Birtholace (State or **Funeral** Months Days Hours Director Country) MARY LAND 2 XF 50 11-13-1956 219-70-3624 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits YYes 2 No 28a-f show N/A BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygtene and File Health and Mental Hygtene to Hill File and 23a or 28a-f sho not If Hieron 27 is marked other than "natural", or items 23a or 28a-f sho not other traumatic event, the Medical Examiner must be notified at once, other traumatic event, the Medical Examiner must be notified at once. MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21218 USA 801 E. 33rd ST. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Never Married 2 X No Yes Yes, Give Year 1 Yes 2 X No specify BLACK Widowed Divorced 4 Specify. 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 LABORER OLES ENVELOPES -2**-**18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) EDDIE PRIDE DOROTHY CREIGHTON Be ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALLACE DODD (HUSBAND) 3308 ECHODALE AVE. BALTIMORE, MARYLAND 21214 Pages 1 and 2 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date crematory or other place) Burial Removal from State METRO CREMATORY 1-8-2007 BALTIMORE, MARYLAND tant: or ot Donation Specify HIBNER Name and Address of Facility 21. Signature JON PHILLIPS FUNERAL HOME, P.A. 721 – 27 N. MONROE ST. BALTIMORE.

Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o BALTIMORE MARYLAND 21217 23a Par I. Enter the disease, or complications that cause Approximate Interval **Physician** Between Onset and fail re List only one cause on each line /Medical Death Cause (Final disease Methadone and alcohol intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical g physician a XUNPENDED AMENDED #23a,27,28a-f g863m 1/12/07 TT perME. Division of Vital Records, P.O. Box 68760, IF FEMALE. 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown igned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy nerformed? death? certificate ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 25 Was case referred to medica 26.Place of Death (Check only one) Be Hospital. examiner? Other₄ this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 2 After 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d Describe how injury occurred Certification: Natural death death Yes 2 X No Pending the Funeral Director: 1/2/2007 12:28 am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be or Town, State) 2714 Tivoly Avenue determined friend's residence Baltimore. 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie cla O.C.M.E. January 2, 2007 cisha 30 Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) JAN 1 Registrar

			For State Registrar	State of Maryland	•	artment of He tificate of D			ene 0 0 7	00330
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Donald Guy Finl	c, Sr				January	6, 2007	4:00 A M
ř	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or I	ocation of Death	1	4c. County of De	
ı			2102 Round Hill I				11ston			rford
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday). Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
H	Director		198-22-4433	75	TIS.			April 21	,1931 Pe	ennsylvania
	and		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	f sho	ō	Marvland Harfo	a w d		Fall	aton			1 ☐ Yes 21 No
	the t	Jec.	Maryland Harfo	ora		10f. Zip Code	Ston	10	ng. Citizen of What	Country?
	Sa or	٥	2102 Round Hill Ro	vad.			21047		U. S	Δ
	ms 2:	Funeral Director		2. Was Decedent Ever in U.S	3. 13.	Was Decedent of His f Yes, specify Cuban		pecify Yes or No-	14. Race - Ar	nerican Indian,
ယ	or Ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 X No	i i		Specify:	o rican, etc.)	Black, W	nite, etc.
9	rel', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		222100	эрвену.		Specify.	White
21215-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-1 show disal Examinat must be rediffed at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of wor	rking	16b. Kind of Busine	ss/Industry
2	within ene. then "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)					A . C1	
N	be filed within 72 hours after death with the Marylan stal Hyglene. id other than "naturel", or flems 23a or 28a-1 show event. The Madical Examiner must be rediffed at		12th Grade 17. Father's Name (First, Middle, Last)		Auto	Body Pai		ne (First, Middle, M	Auto Sho	<u>) p</u>
anc	Mental Harked of arked of atic ever	Be	Guy O. Fink					nie May We		
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importants if item 27 is marked other then any injury or other treumatic event. In Managing.	ို	19a. Informant's Nama/Relationship (Typ	ne, Print)	19b. Mailir	ng Address (Street ar				, Zip Code)
S	and 2 s ealth ar n 27 le ner treu		Martha Fink (Wife)		2102	Round Hi	11 Rd	Fallston	. Marvlan	d 21047
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place	300		20c. Location - City	
Ë	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		of Faith	1	0/2007	Baltimore	, Maryland
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service bicense							me of BelAir
Ö	permi Depa Impo any ii		グント		In	ic, 610 W.	Macpha:	il Rd., B	el Air, N	id. 21014
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. e cause on each line.	. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	Chronica	listu	tropul	Luone	Lucen		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	- 0	٥			
В	Examine	L.	Sequentially list conditions, b	. Due to (or as a consequ	ence of):					
	ied Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a consequ	01100 017.					1
•	xecul	xan	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	cate be executed physician and s the burial-transit									
9	tificate ig phy as the	Physician/Medical							I	
Box	eath certifi attending I I for use as	N/U	23b. Was decedent pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)			Month	Day Year
P. 0	that the de led by the a detached i	Phy	9 Unknown				. In Death	02a Did tak	acco uso contribute	to the cause of death?
	Se Dec	by	Part II. Other significant conditions con	tributing to death but not resu	iiting in the u	nderlying cause give	nin Faiti.			Probably 4 Unknown
orc	w require been si should I	sted	- Jan					-		
Records,	le law has b ge 2 sl	Completed						24a. Was a autops perform	y prior	autopsy findings available to completion of cause of
<u> </u>	ate pag	Ö						1 ☐ Yes 2	2 No 1 1 Y	es 2 No
Vital	Phyeicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only on	<i>e)</i> ance 6 □Other <i>(S</i>	
of	Phye r this ral di	1.	1 Yes 2 No	1 ☐ Inpatient 2 ☐ £	28b. Time o	f 28c. Injury	at		ow injury occurred	респу)
on	Attending Frdeath. sctor: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? ′es 2 □ No			
Division		ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (St City or Town		Rural Route Number,
Ö	tel or s afte el Dir	Certification:	1 Tollinoide	Ballding, oto. (Dposity						
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edicai		sician: To the best of my knowner: On the basis of examinat and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Me	onth, Day, Year)
)	6		Dave 50			03-	2299	3	TANVACY	8, 2007
	压		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре	Print)			•	,
7			31. Date filed (Month, Day Year)	32. Registrar's Signat	ture La	1 1501	916 12	210	′ 7	
	Sta Regist		31. Date filed (Month, Day, Year) 1 0	2007	S.	GOOKEL)				

			1- For State of Maryland / Department of Health and N Registrar Certificate of Death		£ 0 0	7 003	31
			Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of	Death
	Physici /Medic		Pauline Fia La	Month	O S	Vear 505	pm
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County	of Death	-1
			Glen Meadows Ret. Comm. Baltimore		Balt	imore la	unty
	Funeral		5. Social Security Number 130-12-8574 6. Sex 1 \square M 2 \bigvee F 94 Yrs. Ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day Aug. 7.	h y, Year)	Birthplace (State of Country)	r Foreign
	Director		Usual Residence of Decedent	Aug. 7,	1912	Ohio"	
	yland Iow		10a. State 10b. County 10c. City, Town or Location			10d. Inside Cit	ty Limits
	a-fet	tor	Maryland Baltimore Glen Arm			1 ☐ Yes	2 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	-	
	ath w 238	ral	11630 Glen Arm Road 21057		u.s.		
	tems per m	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Signer Specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Year or Dates:		Specify	: White	
Ö	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28s-f ehow ant, the Medical Examinational Reprofilied at	Completed by Funeral	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	usiness/Industry	
215	e. en "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	king			
7	ed wil	Con	11 Vining Room Manager		Golf C		
<u>n</u>	be fill d oth even	Be	17. Father's Name (First, Middle, Last) Paul Surovich 18. Mother's Nam Man			ne)	
Maryland 21215-0036	should be nd Mental marked c	Ç			rarac	Ch. 71 C-41	
Ma			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 10hn P. Fiala (Son) 1802 Ridgecroft Drive				
<u>6</u>	permit. Pages 1 and 2 Department of Health s Important: If item 27 ti any injury or other tre		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State	
Ë	Pages nent of I int: If it		I Dullar 2 Crementor 3 Stremoval non State	12007	Sloony	Hollow, NY	
Baltimore,	permit. Departm Importa any inju		21. Signature or tune and Address of Facility Sc				
<u> </u>	8358		9705 Belair Rd., B	altimore	2, MD 21	236	
			23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac second failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition			Onset and I	A/I)
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				1
į.	STATE OF	7	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				W.
	nted I Insit	mine	cause. Enter Underlying Cause (Disease or injury			3	
Ć,	exection and and rial-tra	Examiner	that initiated events c. The sulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	Physician/Medical	d				
9	ing pt	Med	IF FEMALE:				
Вох	death certifica attending pt d for use as t	lan/	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal death} \) 3 \(\subseteq \text{Ectopic pregnancy} \)		23d. Dat Mor	e of delivery nth Day Y	'ear
о О	the hec	ysic	1 Yes 2 No 9 Unknown			,	
۵.	that the	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contr	ibute to the cause of de	eath?
rds,	w requires that been signed be should be det	d by	DEMENTIA	1□ Y	es 2 No	3 Probably 4 □U	Inknown
Record	s bee	Completed		24a. Was a		Vere autopsy findings a	vailable
Re	Physician: The law r this certificate has b aral director, page 2 s	omo		autop perfor	med?	prior to completion of ca leath? ☐ Yes 2☐ No	tuse of
Vita		Be C	25. Was case referred to medical examiner?	th (Check only or			
<u>></u>	hysic his ce il dire	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho	ome 5 Resid	ence 6 Othe	ar (Specify)	
n C	ing P	on:	27. Manner of Death 1 Shatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurr	ed	
Division of	or Attending Physician: after death. Director: After this certifica in by the funeral director, i	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined Suicide Suicide Could not be determined Suicide Suicide Suicide Could not be determined Suicide Su	28f Location /S	troot and Number	er or Rural Route Numi	har
2	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow		er or Hurar Houle Numb	<i>9</i> 67,
	Hospital 4 hours Funeral tely filled	alc	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the o	ause(s) and ma	nner as stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, o	date and place, a	and due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of pertitier 29c. License number	2	29d. Date signed	(Month, Day, Year)	
ŀ	,5		FAMAN H WOTHLAN MAD 251228		1/6/2	200+	
	le "		30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) RAMANA COPALAN M.D. ZE. ROLLING (RUSS ROAD)	Hica	RACTIO	10RE 212	70
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 TO	440 -(11	100-6 717	-0
	Registr		JAN 1 0 2007 Januar De porte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 (1)

1- State Amend #29d, perMD, 6863, 1/10/07 IT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gerald T. Graham January 4, 2007 11:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 3, 19 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 234-24-5780 82 Vrs June 1924 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Baltimore Perry Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 C Brook Farm Ct. 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Engineer Electrical traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tames Graham Laura Topping ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Mrs. Mella R. Graham (wife) 18 C Brook Farm Ct., Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem'l Gard 1/8/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear Immediate Cause (Final Physician homa disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contribut Hing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury
(Manth. Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, neral Director; A within 24 hours a To the Funeral I

the Maryland

28a-f show

Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Items 23;

Baltimore, Maryland 21215-0036

Medical 101

State

Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N-Charles St. Balto-M1 21205 GAMC

31. Date filed (Month, Day, Year) 2007

29a. Certifier

(Check only one) 29b. Signature and title

> 32. Pégistrar's Signature A SALLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2033M Clarence Gardener 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner INTON memoria NIA If Under 24 Hrs.
Hours Min. (In yrs. last birthday)

Yrs. 8. Date of Birth (Month, Day, Year) October 9, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year **Funeral** 1 M 2 F Months 249-22-4929 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or iteme 23e or 28a-f ehow the Medical Examiner must be notified at 1 Tes 2 No MD Baltimore Director NA 10e. Street and Number 10g. Citizen of What Country? be filed within 72 hours after death with 3844 21218 Alameda USH Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 70 1 Never Married 2 Married 1□Yes 25 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "neturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 88 Master Driver permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy importent: If item 27 is marked othen y njury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Gardener Gardener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doro thy E. Gardener/wife 3844 The Alameda Bultimore MD 21218 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State King menonal Park 1/13/07 Ballmare County. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Baltomore mp 21206 5126 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory

Due to (or as a consequence of): Physician Arrest disease or condition resulting in death) /Medical Examiner 10 days Preumonia Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed 10 years Alzheimer's demontic resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4□Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun. Dawn AT2438946 January 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baronas M.D. Union James Memorial Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 0 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Aaron Carvel Guard \mathbf{a}^{M} 2007 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sligo Creek Nursing & Rehab Center Park If Under 24 Hrs. Montgomery Takoma If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 578-34-2690 Director 78 3-4-1928 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MDMontgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Sligo Avenue 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sign Painter unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ant: If item 27 Is marked ott Be ပ George Guard Bulah Dameron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Guard/son 7111 Holly Ave. Takoma Park, MD20912 or other 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any Injury or once. 4 Donation 5 Dother (Specify) Chesapeake Crematory 1-9-2007 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Silver Spring, MD Rapp Funeral & Cremation Svc933 Gist Ave20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Obstructive Lung Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 1 ☐ Yes 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1/8/07 D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111/ Spring St. Silver Spring, MD 20910 Yeheyis Negussie 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 1 0 2007 Registrar

				partment of Health and Nertificate of Death	Mental Hygien	2001 00000
ľ	Physici /Medic		Decedent's Name (First, Middle, Last) GEARY	GREENBERG	2. Date of Death JANUARY 7	3. Time of Death 6:00 P M
	Examir		4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE	4b. City, Town, or Location of Death	UM	c. County of Death BALTIMORE
ŀ	Funeral Director		5. Social Security Number 216-56-5625 Usual Residence of Decedent 6. Sex 1	Months Days Hours Min.	8. Date of Birth 11/30/195	9. Birthplace (State or Foreign Country) MD
	e Maryland Ba-f show htified at	Director	10a. State 10b. County 10c. City, Town or	Location LTIMORE		10d. Inside City Limits 1 ☐ Yes 2
	ath with the 23a or 23		35 STONEHENGE CIRCLE #5	10f. Zip Code 21208		Citizen of What Country?
900	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerform 1 ☐ Yes 2 X No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	ed within 72 h giene. er than "natu , the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CC	cedent's Usual Occupation ve kind of work done during most of work v. DO NOT use retired) MPTROLLER	king	Kind of Business/Industry CCOUNTING
Maryland	2 should be filed vand Mental Hygie is marked other raumatic event, the	To Be (JOSEPH GR	EENBERG CHARLOT	ne (First, Middle, Maide TE	en Surname) ASKIN
	permit. Pages 1 and 2 should by Department of Health and Mente Important; if Item 27 is marked any Injury or other traumatic en once.		BARRY GREENBERG / ATTY. & COUSIN 2		2115 - BAL	
Baltimore,	Pages 1 ment of H ant: If Iter ury or oth		1 N Burial 2 Cremation 3 Removal from State	position (Name of rematory or other place) E HEBREW CEM 01/0		Location - City or Town, State EISTERSTOWN, MD
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licensee			N & BROS., INC. KESVILLE, MD 21208
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MULTIPLE MYELOMA	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	-		
oʻ.	cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Finter I not reprint Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
68760,	tificate be g physicia as the bur	ledical	d			
.O. Box	the death certific y the attending p iched for use as	Completed by Physician/Me		B⊟Ectopic pregnancy 5 ☐ Other <i>(specify)</i>	·	23d. Date of delivery Month Day Year
Δ.	n requires that the de been signed by the s should be detached i	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2□ No 3□ Probably 4 X Unknown
Division or Vital Records,	The law ate has b	Be Comple	25. Was case referred to medical	26 Place of Deal	24a. Was an autopsy performed? 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1	
or V	ding Physician: After this certific funeral director,	은	examiner? 1 ☐ Yes 2 ▼ No	ent 3 DOA Other: 4 Nursing He	ome 5 Residence	6X Other (Specify) HOSPICE
vision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	1 X Natural 5 □ Pending investigation 3 □ Suicide 6 □ Could not be determined 4 □ Homicide	/ Work? M 1	28d. Describe how inj	and Number or Rural Route Number.
ō	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/o	ath occurred at the time, date and place	City or Town, Sta	(s) and manner as stated
	To the within 2 To the complet	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)
	~)	D43725		1/7/67
1	5 1		30. Name and address of person who completed cause of death (Item 23a) (Typ. DR. TARIQ MAHMOOD 2300 DULANEY VAL		MD 21093	
	Sta Registr		31. Date filed (Month Pay Year) 2007 \$2. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Patrick Hall State of Maryland / Department of Health and Mental Hygiene 00336 1. For State Certificate of Death Reg No Registrar 1 Decedent's Name (First Middle Last) Physician/ 2. Date of Death **Medical Examiner** 1928 hrs Richard Ρ, Hall January 1, 2007 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birtholace (State or Months Days Min Director Hours 180-34-7280 12/15/1944 Pennsylvania 1 XM 62 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 Yes 2 X No Marvland Anne Arundel Glen Burnie hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at 6410 Lamplighter Ridge 21061 United States 238 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, or items Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 White etc. Married 2 X No Yes 3 X Widowed Specify: White If Yes, Give Year Yes 2 X No specify. "natural", Examiner \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene Important: If item 27 is marked other than "ni injury or other transmatic event, the Medical Es. Elementary/Secondary (0-12) College (1-4 or 5+) cs 1 and 2 should be filed within 72 l of Health and Mental Hygiene If item 27 is marked other than ", ther transmatic event, the Medical E 5 Therapist State of Maryland 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joseph Hall Blanche Unk 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Hall, Daughter 3313 S. Keswick Circle, Philadelphia, PA 19114 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Removal from State Philadelphia Crematories |01/12/2007 Philadelphia, Pennsylvania Donation 5 Other Specify 22. Name and Address of Facility gnature of Funeral Service Licensee M01113 McCafferty-Sweeny Funeral Home SHamua 6126 Torresdale Avenue, Philadelphia, PA 19135 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Between Onset and Narcotic and cocaine intoxication Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical physician a X UNPENDED AMENDED #23a,27,28a-f, perME, g863, 1/12/07 TT Box 68760, 23c if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? To the Hospital or Attending Physician: The Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 ဥ ✓ Yes No 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No Pending To the Funeral Director: /1/2007 unknown 2 Accident Fnd 6:37 pm Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. . Location (Street and Number of Rural Route Number, City or Town, State) 6410 Lamplighter Ridge 3 6 X Could not be Suicide determined (Specify) residence Homicide Hen Burnie, MD 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 2, 2007 Croke 30. Name and address of person who completed cause of death (Item 23a)

State

Registra

Tasha Greenberg MD.

2007

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** NORMA L. 3, ISER 2007 12:25 P JAN. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE OF SEVERNA PARK SEVERNA PARK ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛱 F Yrs Director 82 235-24-1950 19, 1924 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Iteme 23e or 28e-f ehow The Medical Exeminer must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 1010 PHILLIP DRIVE 21061 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify. ð 3 ☐ Widowed 4 ☑ Divorced permit. Pages 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural any injury or other traumatic event, I'm Medical E., 2006. WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE DIRECTOR LEGAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY L. LOUGH ဂ BESSIE ANTILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN LOUGH / BROTHER 1010 PHILLIP DR. GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State JAN. 4, 4 Donation 5 Other (Specify) METRO CREMATORY 2007 CATONSVILLE, MARYLAND 21. Signature of Funeral SA ice Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. ET. 0 421 CRAIN HWY. SE GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Depsis **Physician** -2 days /Medical Due to (or as a consequence of) Examiner vascular dispase Peripheral
Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physicien a d be detached for use as the burial-I Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ disease 1 Yes 2 No 3 Probably 4 Donknown TOr Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy 1 ☐ Yes 21 No spitel or Attending Physicien: Thours after death.
Inserel Director: After this certificet y filled in by the funeral director, ps 25. Was case referred medical examiner? Be 26. Place eath Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Toursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50725 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print) 0 Veterans Hwy Millersville MD Jenn, for 8601 Kiedinger 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12.00 AM Sharon Doreen Jackson 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Sinai Hospital of If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months 214-72-8537 48 Yrs. Director 01/07/1959 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 XYes 2 No MD Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 737 North Milton avenue 21205 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ ^{Specify} African American 3 Widowed 4 Divorced "natural", Completed any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) accountant Zurich Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ၉ Harold C. Jackson Mary Stanback 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Carole Jackson / Daughter 737 North Milton Avenue; Baltimore, Maryland 21205 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Cemetery 01/13/2007 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small **Physician** cell cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. detached 2 🖼 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 2 ER/Outpatient 3 DOA To the Funeral Director; After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? To the Hospital or Attending Injury 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

atient

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Hospital

MU

32. Registrar's Signature

Sinai

no,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIBERG

RES

000

of Baltimore, 2401 W Belvedere Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 23 A M **Physician** JAROMIN - RANK 200 F /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSP (TAL SACTITIORE (ERLY II Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 3,1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**⋈**M 2□F Months 212-03-0738 88 Director Aug Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at XXYes 2 ☐ No Director N/AMd Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 815 S. Belnord Aveune 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. iled within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 is marked other than Elementary/Secondary (0-12) Factory Worker Star Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valinti Jaromin Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Pamela Vincent - Daughter 9212 Bretton Recf Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Department of Important: If sny Injury or once. St. Stanislaus Cem. 1-10-07 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, 21. Signature of Funeral Service Licent 1201 Dundalk Ave. Baltimore, MD 21222 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SALLER S_uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ending physicien end use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 dinknown LOWAR 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificete 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Medical Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 5 ☐ Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the funs 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) BACTIME NO ZIZUZ PLACE 501 JOSEPH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

ORIGINAL

الدادامسم	Baltimore.
7	
	P.O. Box 68760.
	ital Records

			Please			ck Indelible Inlock Department of Certificate of	Health and			007	00342
	* 1.8	2	Decedent's Name (First, Middle, Las	1)				2. Date o	f Death		3. Time of Death
	Physicia /Modic	- 4	Aubreyona		Kin	3		Month	Day	2007	0830 M
	/Medic Examin	1 4	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of De	ath	4c.	County of Deat	
). 1 · 1	Sing Hi	SP. TAL		BA	Ltima			N/	
	Funeral Director		N/A	7. Ag	e (In yrs. last t	irthday) If Under 1 Yea Months Days		n. (Month	f Birth , Day, Year) 1 2007	Co	thplace (State or Foreign buntry) MD
	and **	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
	denyl	ō	MD N/A		Ba.	ltimore					1 ∑Yes 2 □ No
	r 28a	Director	10e. Street and Number		l	10f. Zip Code			10g. Citi	zen of What Co	ountry?
	3a o		5818 Loch Ray	zen Blyd.		21	239		r	JSA	
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? ban, Mexican, Pue	(Specify Yes o	r No-	14. Race - Ame Black, Whit	
036	ours after al', or Ita Examine	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ f If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐XN					Black
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or teme 23a or 28a-f ehow event, the Medical Examiner must be notified at event,	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e during most of w	rorking	16b. Ki	nd of Business	findustry
21	giene giene er the	Com	N/A	N/A		N/A				N/A	
p	ould be filed with Mental Hygiene arkad other tha atic event, the h	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Mi	ddle, Maiden	Sumame)	
<u>ya</u>	should by ind Menta i marked umatic ev	ဥ		avon		Foreman	Eth		/lae	King	
	. a		19a. Informant's Name/Relationship (7		19	b. Mailing Address (Stree					
αĵ	of Health of Health Item 27		Ethel King-mothe	er	20b. Place	5818 Loch F of Disposition (Name of	aven BIV	O. Balt		cation - City or	21239 Town. State
ŏ	if it		1 Surial 2 ☐ Cremation 3 ☐		сете	ery, crematory or other p		0/2007			
Baltimore,	it. Partmer		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		KING	Memorial Pa	roce of Eacility			ndallst	
Ba	permit. Pages Department of h Important: If Its eny Injury or of		D Q Q.	a 142						HOME-I	
	-		23a. Part1. Enter the disease, or comp	olications that caused	the death. D		North Av ying, such as card			e, MD	21202 Approximate Interval Between
	Physician		shock, or heart failure. List only a Immediate Cause (Final			~ 1 .					Onset and Death
	/Medical		disease or condition resulting in death)	A	a consequence	nRity					
	Examiner		Out and the first are distance.	b							
*	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initial and the conditions)	Disa to (or as	а попведиали	6 of):		-			
	ocuted ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	s be executed sicien and burial-transit	al Ex	resulting in death) cast	Due to (or as	a consequenc	e of):					
6876	cate b	dlca		d							
Вох 6	The law requires that the death certificate to the law requires the last been signed by the attending physic age 2 should be detached for use as the board.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea	th 3 Ectopic pregnar 5 Other (specify)				23d. Date of de Month	livery Day Year
0	that the de ned by the a detached f	hysi	9 Unknown	9□ Unknown							
Records, P.	uires that signed to lid be det	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the underlying cause of	given in Part I.		Did tobacco u 1 □ Yes 2 l		o the cause of death?
00	w require been si should I	Completed							Was an	24b. Were a	utopsy findings available
Re	The law te has age 2 s	L O						1 🗆 Y	autopsy performed? es 2 X No	death?	completion of cause of
Vital		0	25. Was case referred to medical				26. Place of D	Death (Check of		10.103	2010
<u> </u>	Physician: r this certific ral director.	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatie	ent 2 ERV	Outpatient 3□ DOA	ther: 4 🗆 Nursing	Home 5	Residence	6 □Other (Spe	ecify)
0	ding Pt After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28t y Year)	. Time of 28c. In			ribe how injur		
Sio	uttendir death. ctor: Al y the fu	catle	2 ☐ Accident investigation			M 1	☐ Yes 2 ☐ No				
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace 01 III	ury · Al home, c. (Specify)	farm, street, factory, office	е	28f. Locat City o	ion (Street an r Town, State	d Number or R)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C			f examination	ge, death occurred at the and/or investigation, in my					
	To th within To th compl	Me	29b. Signature and title of certifier	1		29c. Lice	nse number			e signed (Moni	
	d		Sudilar	Mille	MI	P	18631		01	-04-	2007
	1		30. Name and address of person wh	mpleted cause of	death (Item 23	a) (Type, Print)	1				
_			SADEK	+ Just	QN.	29c. Lice	LOSPITA	L			
100	I Chickey	110	31. Date filed (Month, Day, Year)	32. Pagisti	ar's Signature	4					
	Sta Regist		2544 6	2007	A	Brank 8					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MIKHAIL KOGAN Jan 1437 07 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Ballimore N/A Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. 0371671916 RUSSIA 90 218-75-3731 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RUSSIA 21215 6960 MARSUE DRIVE #1-D by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 No Specify: Specify. 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 CLOTHING TAILOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KOGAN LUBOV (UNKNOWN) MOSES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau MARINA BRAGINSKAYA / DAUGHTER 6960 MARSUE DRIVE #1-D BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State BALTIMORE HEBREW CEM 01/09/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mar 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trans Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WARKINSON DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy perform LUNG MASS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ♣️♣️¶o certificate has 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred al or Attending P s after death. Certification: 1 Accident 5 Pending (Month, Day Year) Injury investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

AMAN SIDAL, MO 31. Date filed (Month, Day, Year)

JAN 10

HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINN HOSPITAL OF

Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

DHMH 17 Rev 1/2001

D0061959

BALTIMORE, 2401. W BEVEDERE

AVE , BALTIMORE, MD 21215

ş

State Registrar

Medical

hristine 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

ene.

a

(Check only one)

32 Registrar's Signature



tospitalist

5401

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

62912

29d. Date signed (Month, Day, 2007

7

Maryland

Januar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Daniel Joseph Kucharczyk January 2007 12:45P.™ /Medical 4a. Facility Name (If not institution, give street and number)Baltimore 4c. County of Death 4b. City, Town, or Location of Death Examiner Rehabilitation Extended Care Center Baltimore 6. Sex XXM 2□ F If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb27, 1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-32-4748 70 Director Maryland Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28e-f show 1 ☐ Yes 2 No Director Md. Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6840 Boston Avenue 21222-1038 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r then "naturel", or iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after a Health and Mental Hygiene. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Mail Clerk Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kucharczyk Martha (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6840 Boston Ave. Baltimore, Md. 21222 Date 20c. Location - City or Town, State Rose Kucharczyk (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages Inent of Fant: If ite 1 Burial 2 Cremation 3 Removal from State Most Holy RedeemerJan8,2007Baltimore, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician <u>Rectum_Cancer</u> Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Itending physicien and A Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ঠ in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) forms after death.

John States death.

John States death.

filled in by the funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: XXNursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 00 anuani 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tan, M.D. 3900 Loch Raven Boulevard Baltimore,

State

DHMH 17 Rev 1/2001

Registrar JAN 1 0 20

31. Date filed (Month, Day, Year)

32. Registrar's Signature

figuralis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 01 Month 2. Date of Death 3. Time of Death 0 7 Day 2ÕÕ7 Evelyn Frances Latimer 12:00p 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charlestown Retirement Care ceh. Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-04-1915 Catonsville Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 □ M 2 X F 516-10-5361 Montana Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6201 Maiden Choice Ln.Bldg709 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 o Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Administrator Religion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gutav Carl Wendt Jr. Minnie Isch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Alexander/daughter 3563 Ft. Meade Rd.Laurel, MD20724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation Chesapeake Crematory 22. Name and Address of Facility 8717 Green Pastures Dr. 1-10-2007 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee mo1358 Cremotion + Funeral Alternatives TOWSON MD 2128C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End stage ranal discase Sequentially list conditions, if any, leading to immediate caus. Enter or senting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner The law requires that the death certificate be exect Division or Vital Records, P.O. Box 68760,

attending physician for use as the buria tate has been signed page 2 should be det To the Hospital or Attending Physician: funeral director, After this within 24 hours a er death.

To the Funeral Lirector A completely filled in by the fi

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene. Is marked other than

Department of Health a Important: if item 27 Is any injury or other trains

Physician /Medical

Pages

filed within 72 hours after

Saltimore, Maryland 21215-0036

Medical Certification: To

4 Homicide

29a. Certifier (Check only one)

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jan 57 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maiden Choice Lane Catonsville

Myld M Carpanter
31. Day filed (Month, Day, Year) 32

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D30989

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar		aryland / L		tificate of L	Death		Reg. No.	07	00347
	Physici /Medi		1. Decedent's Name (First, Middle, L LeRoy J. Misk						2. Date of De.	Day	Year 07	3. Time of Death 9-45-PM
•	Examir		4a. Facility Name (II not institution, gi Genesis Elderca		Raven		4b. City, Town, or Baltime			4c. Count	y of Death	
	Funeral Director		219-12-7543	. M	e (In yrs. last bir § 9	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Sept. 6	lh.	9. Birth	place (State or Foreign ntry) LYLand
るるが、	ehow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	10d. tnside City Limits
2	the Man 28a-feh notified	ctor	Maryland Baltimo	re		Pe	rry Hall					1 ☐ Yes 2 No
K	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?
N	eath v	eral	2C Brook Farm 11. Marital Status	12. Was Decedent	Ever in 11 C	12 14		21128	noify Vac or No		A.	can Indian,
]]]	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23a or 28a-f ehow he Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X			Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Bla Specil	ck, White,	
7.0	72 hou	eted	15. Decedent's E (Specify only highest gi	Education	16a.	Deced	ent's Usuat Occupa	ition	ng	16b. Kind of B	lusiness/In	dustry
10/07 M	2 should be filed within 72 ho and Menial Hygiene. Is marked other then "naturatic event, I'm Medical	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5	i+)		ineer	uring most of worki	ng .	Rail	road	
) E	uld be filed Mental Hygi arked other tilc event, i	To Be	17. Father's Name (First, Middle, Las Arthur Miskimo	•				18. Mother's Name	(First, Middle, Thomas		ne)	
1 2	d 2 should th and Mer 7 le marke traumatic	F	19a. Informant's Name/Relationship		19b	. Mailing	Address (Street a	nd Number or Rura			, State, Zip	Code)
			Carol Zysk	(daughter)	97	725	Harvester	circle,				
Baltimore	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 1		20a. Method of Disposition 1	Removal from State	20b. Place of cemeter	f Dispos ry, crem	ition (Name of atory or other place	,) C	ate	20c. Location	- City or To	own, State
<u> </u>	t. Pag rtment rtant: rjury o		4 Donation 5 Oher (Speci	(ty)	Oak La		Cemetery	1/11/	2007	Baltimo	re, N	laryland
a	permi Depa Impo any in		21. Sknati Funeral Skrijcé Lice	airif.		9	705 Belai	s of Facility Sch Tr Rd., Bo	imunek altimor	Funeral .e, MD 2	Home 1236	28
•	Physician /Medical Examiner		23a. f a Kenter the disease, or con show, or heart failure. List only Immedia e Cause (Final disease or condition resulting in death)	a	10./	00		e, such as cardiac o		nost. NOn7	54	Approximate Interval Between Onset and Death
ı	ped list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence (of):						
68760	rificate be executed ng physicien and as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence (of):						
	rtificate ng phys as the	Aedical	IF FEMALE.					a		7/11		
O Bo	The law requires that the death certie has been signed by the attendings 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			4.7	ite of delive onth	ery Day Year
0.	s thet I	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in	n the un	derlying cause give	n in Part I.	23e. Did to	obacco use con	tribute to th	he cause of death?
, de	w requires been sign should be								101	res 2□No	3 Prob	ably 4 Unknown
Division of Vital Records D O	The law rete has be page 2 sh	Completed								med?	prior to cor death?	psy findings available mptetion of cause of
Z:	ician: T certificet rector, pi	Be	25. Was case referred to medical examiner?	Hospitat.			Otho	26. Place of Death	-	100		
T	Phys	5	1 ☐ Yes 2 1 No 27. Manner of Death	1 Inpatie	v 28b T	tpatient		4 Nursing Hor		lence 6 Oth		iy)
i	Attending Physician: r death. sctor: After this certific by the funeral director, i	atlor	1 Naturat 5 Pending 2 Accident investigation	(<i>Month, Da</i> y in	γear) In	njury	28c. Injury Work' M 1 □ Y	? es 2 □No	.00. 50001501	iow injury coccur		
<u> </u>	tal or Att is after de al Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined		ury - At home, fa c. (Specify)	rm, stre	et, factory, office	2	28f. Location (S City or Tow	Street and Numb vn, State)	oer or Rura	al Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the for	edical	29a. Certifier 1 Certifying Pi (Check only one) 2 Medicaf Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	death dor inve	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the ded at the time, d	cause(s) and madate and place,	anner as st and due to	tated. o the cause(s)
	To the within 2 To the comple	¥	29b. Signalupe and little of certifier	49nding	Phy s	Sizu	29c. License	number 5 6 4	2	Jan.	d (Month,	Day, Year)
	12		30. Name and address of person who	completed cause	eath (Item 23a) ((Type, P	Karlos	St. 4	-202 E	Balti	mor	e 21204
- 1	Sta	ite	31. Date filed (Month, Day, Year)	32. Aggistra	ar's Signature		-					

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	State of Maryland	d / Depa		ealth and M	lental Hyg	•	7 00348
1	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last MARLO W 4a. Facility Name (If not institution, give BEN SECOUN	MART	IN		Location of Death	2. Date of Deat Month	th Day Ye	3. Time of Death 7.07 A
	Funeral Director			7. Age (In yrs. Is			If Under 24 Hrs. Hours Min.	8. Date of Birth 01/26/195	9. 3 ^{year)}	Birthplace (State or Foreign Country) MD
	within 72 hours efter deeth with the Maryland ane. than "natural", or itema 23s or 28s-f ahow ta Madical Exerciter must be mulliad at	rector	10a. State 10b. County MD 10e. Street and Number	10c. City	r, Town or Lo	Baltino 10f. Zip Code	ore	1	0g. Citizen of Wha	10d. Inside City Limits 1 X Yes 2 □ No
	23a or	rai Di	1430 Pennsylvania Ave	nue Apt. 203			21217		USA	
920	al', or itema	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. rican American
21215-0036	ges 1 and 2 should be filed within 72 hours efter deeth with the Marylan it of Heelih and Mental Hygians. If Item 27 is marked other than "natural", or Itema 23s or 28s-1 show or other traumatic avent, the Modical Examination at the nutilitied at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 10th	ication (e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired MOVET	turing most of work	ing	16b. Kind of Busin Morto	ess/industry n Moving Factory
Maryland 2	should be filed ind Mental Hygis marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) John Henry				18. Mother's Name	Ruth Grav	res	
Mar	nd 2 sho alth and 27 ia m r traum		19a. Informant's Name/Relationship (T) Deborah Martin / Sist			ng Address <i>(Str</i> eet a 30 Pennsylva			-	
Baltimore,	L'A		20a. Method of Disposition 1	Removal from State	emetery, crei	osition (Name of matory or other place rial Park	01/10/		20c. Location - City Randallstow	y or Town, State n, Maryland
Balt	permit. Pe Depertmen Important: any injury 2008.		21. Signature of Funeral Service Licens	one	22	2. Name and Addres	ss of Facility W nor Street;		ral Home, P	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ications that caused the death ne cause on each line. a. Human Due to (or as a consequence) Due to (or as a consequence) Let Para	ience of):		g, such as cardiac of deficience		gndvovu	Approximate Interval Between Onset and Death
68760,	Physician: The law requires thet the death certificata be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be deteched for use as the burial-transit	cai	resulting in death) Last	Due to (or las a consequent of the consequent of	ience of):	relit	7'S			
P.O. Box	thet the death cer ed by the ettendir deteched for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P	uires thei signed t	b	Part II. Dther significant conditions co	ntributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did tob		te to the cause of death? Probably 4 Unknown
I Records,	sician: The law require certificate has been sli irector, page 2 should b	Completed	Chose	Renal	ins	Afric	iency	24a. Was all autops perform	n 24b. Were	
of Vital	ysician: The iis certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospital:	-0.0	ot 3 DOA Othe	26. Place of Death	(Check only on	θ)	
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification: To	27. Manner of Death 1 SNatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At hor	28b. Time o Injury	f 28c. Injury Work	y at (?? Yes 2 □ No	28d. Describe ho		or Rural Route Number,
ā	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical Cert	29a. Certifier IX Certifying Phy	building, etc. (Specify sician: To the best of my knowner: On the basis of examinat	wledge, deat	h occurred at the tim	ne, date and place, pinion, death occurr	City or Town and due to the ca	ause(s) and manne	or as stated. due to the cause(s)
	To the within 2 To the complex	Med	29b. Signature and title of certifier	and marrier stated.	LD	29c. License	rumber 5425	- 29	9d. Date signed (M	donth, Day, Year)
	Sta Registr		30. Name and address of person who could be a second of the second of th	-1.01.1-	Com	Print) Mogall &	bath t	tV, cost	onsville	, MD 21228

07-00	094	
Paul F	dward	Nagel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Certificate	of Death	, 0	g. No. 200	7 0021.0
M 12 -	Physici	an/	Decedent's Name (First, Middle,Last)			Date of Death Month		3. Time of Death
viedic	al Exami		Paul Edward Nagel 4a. Facility Name (if not institution, give street an	d number)	4b. City, Town, or Location	Month January 4,		0656 hrs
			4536 Manorview Road	a number)	Baltimore	or Death	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		er 24Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9 Birt	hplace (State or
	Director		216-88-9319 1XM 2	F 31	Yrs. Months Days Hours	8-15-	-75 Foreig	n untry) MD
			Usual Residence of Decedent					
	w any		10a. State 410b. County	10c. City, Town or Lo				10d Inside City Limits
	Maryland 28a-f show 1 at once.	ģ	MD 10e. Street and Number	Baltimor	10f. Zip Code	140	og. Citizen of What Coun	1 X Yes 2 No
	th the Maryland 23a or 28a-f sho notified at once.	Director			· ·			try ?
	hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once		3421 Kenyon Ave	Decedent Ever in U.S. 13	21213 Was Decedent of Hispanic Ori	gin? (Specify Yes or No-	USA 14 Race - Americ	can Indian. Black.
	r item	Funeral	X NOVO MAINES 2	ed Forces? es 2 x No	If Yes, specify Cuban, Mexican		White, etc.	
	after o	by F	3 Widowed 4 Divorced If Yes, Give	e Year 1	Yes 2 No specify		Specify Whit	e
	hours natur Exam	pa	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College	durin	dent's Usual Occupation (Give g most of working life, DO NOT		16b. Kind of Business/li	ndustry
36	rin 72 Than	ple		ge (1-4 or 5+)	, , ,			-
0	ygien ygien other	Completed	12th 17. Father's Name (First, Middle, Last)	I Tec	chnician 18.Mothe	r's Name (First, Middle, M	Cable Ir	ıd
21215-0036	should be filed within 72 hours afte and Mental Hygiene 7 is marked other than "natural", atic event, the Medical Examiner	Be	Gerald Anderson			bera R. Na		
7,		입	19a Informant's Name/Relationship (Type, Print	10	illing Address (Street and Nur			
2	nd 2 salth		Jennifer R. Nagel 20a Method of Disposition		21 Kanyon Rd position (Name of cemetery,	Baltimore Date	20c. Location - City or	
Raltimore	permit. Pages I a Department of He Important: If its injury or other t		1 Burial 2 XCremation 3 Remov	val from State crematory o	r other place)		,	
į	it. Pay rtmeni rtant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ew cremetory 2. Name and Address of Facilit		Baltimore	MD
ä	Depa Impo						ERAL HOME_	04004
P	hysician		23a. Part I Enter the disease, or complications the failure. List only one cause on each line	nat caused the death. Do not ent	er the mode of dying, such as d	rn Ave Ball cardiac or respiratory arre	est, shock, or heart	21231 Approximate Interval
	/Medical Examiner		•	adone intoxication				Between Onset and Death
/	-xaiiiiiei		The second secon	as a consequence of)				
		<u>-</u> 6	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):			·	
		Examiner	cause. Enter Underlying Cause					
. /	ted nsit	Exa	events resulting in death) Last Due to (or	as a consequence of):			- 5	
٧	cate be executed physician and he burial - transit	ical	X UNPENDED AMEND	ED			·	
760	cate be physici he buri	Medical		#23a_PTT_27_28a yes, outcome of pregnancy	-f. perME. g863, 1	1/19/07 TT	23d. Date of delivery	
687			past 12 months?	ive birth 2	Fetal death 3 Ectopi	c pregnancy		ay Year
89 20	leath certifice attending for use as t	ysician	1 Vac 3 No 0 Unknown	regnant at time of death 5	Other (Specify)		0	
	at the d by the tached	Phy	Part II. Other significant conditions contributions	ing to death but not resulting in t	he underlying cause given in P	art I 23e Did to	bacco use contribute to t	he cause of death?
٥	res tha signed be det	d by	Cocaine use			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
roic	w requir	Completed				24a Was a		opsy findings available ompletion of cause of
200	The lay ate has	шо				perfor	med? death?	
<u> </u>	ysician: The lysician: The lysician: The lysicat	Be C	25. Was case referred to medical examiner?		26.Place of Death	L		
<u>*</u>	Inysici this c	To E	1 ✓ Yes 2 No	Inpatient 2 ER/Outpat		Nursing Home 5 1	Residence 6 🗸 Other	Scene
2	ding Ph After funeral		1 Noticel	Date of Injury Month, Day,Year) 28b. Time			ow injury occurred	
	or Attencafter death Director: Jin by the	cati	2 Accident Investigation	1/4/2007 Fnd 6:		G		
Oivision of Vital Bocords D	pital or A purs after eral Dire	Certification	Suicide O Could not be	Place of Injury - At home, farm, actify) found in house		or Town, St	treet and Number or Ruitate) 4536 Manory	iew Road
_	Hospin 14 hour Friner ely fill	2	29a Certifier	e best of my knowledge, death o	***	Baltimore ace and due to the cause		
	To the Hospital or Attending Physician: The law requires that the death certificate drough and the death certificate drough the functal Director: After this certificate has been signed by the attending completely filled in by the functal director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the ba	asis of examination and/or inves				
	F % F S	Me	29b Signature and title of certifier	0	29c. License number		29d Date signed (Mor	th, Day, Year)
			Hoter Chonica	-tollahm	O.C.M.E.		January 4, 2007	
	0		30. Name and address of person who completed		444 D 01 1 =	liin and the same	,	
	W .	lake		sistant Medical Examine	r 111 Penn Street, Ba	aiumore, MD 21201	I	
	S Regis	tate trar	31. Date filed (Months) Yell 2007	Registrar's Signature				

			1	State of Maryland / Department of Health and M For State Registrar State Of Maryland / Department of Health and M Certificate of Death	lental Hygie		00350
_		Physicia	n	Decedent's Name (First, Middle, Last) JULIA ANNA NOVAK	2. Date of Death Month Jan	Day Year S 2007	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arun	nde1
		Funeral Director		5. Social Security Number 6. Sex 13-14-4636 1	8. Date of Birth (Month, Day, Y May 22,	(ear) 9. Birth Cou 1913 Mar	place (State or Foreign intry) cyland
Ċ,	ryland	how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	<u></u>		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ovah	h the Ma	r 28a-f s notified	Director	Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	
\o\	death wit	ma 23a c	Funeral D	7766 Lawrence Avenue 21122 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 17 Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer Black, White	
ر ک	5-0036 72 hours after death with the Maryland	al', or ita Examina	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify:	White
Anna	21215-0036 of within 72 hours aft	e natur Medical	npieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed	sing 16	Grocery S	
	ਰ ਵੱ	d othar	Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma a Roth	uden Sumame)	
Iulia	Marylan d 2 should be	th and Mental	To	19a. Informant's Name/Relationship (Type, Print) Charles W. Novak (Son) 19b. Mailing Address (Street and Number or Rut 7766 Lawrence Ave.,			
La La	Baltimore,	ο Ο >-		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery 1/13		oc.Location-City or altimore.	
	Baltin	Department Important: If any injury or once.		21. Signature of Funeral Service Licensee Kevin E Ecker 22 Name and Address of Facility Polyniak I 237 E. Patapsco Av	Funeral H ve., Balt	ome, P.A.	1225–1856
•	P	hysician		23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or respiratory arres	dises	Approximate Interval Between Onset and Death
		/Medical xaminer		Immediate Cause (final disease or condition resulting in death) a. Attroplantic Corestovovo Due to (or as a consequence of): Multiplant for demand	tia		ioyears
	3760, A	ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque of of): C. Due to (or as a consequence of):			
	P.O. Box 68760,	To the Hospital or Attanding Phyaician: The law requires mat me deam cerumicater within 24 hours after death. To tha Funeral Diractor: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1		23d. Date of del Month	ivery Day Year
	rds, P.	quires man n signed by uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	Division of Vital Records,	The law reate has bee page 2 sho	Completed		24a. Was an autopsy perform 1 Yes 2	prior to	topsy findings available completion of cause of
	ita	stan: artifica octor, I	Be (examiner?	ath (Check only one		
	on of \	To the Hospital or Attanding Phyalcian: The within 24 hours after death. To tha Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	ion: To	27. Manner of Death 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H 27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 1 Types 2 No	lorne 5 X Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	cify)
)ivisio	or Attand after death Diractor: in by the f	Certification:	2 Accident investigation 3 Suicide 4 Homicide 1 Accordent 1 Accordent 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
	_	Hospital 24 hours a Funeral stely filled	ledical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and on the place 2 Medical Examiner: On the basis of examination and on the place 2 Medical Examiner: On the basis of examiner 2 Medical Examiner 2 Medical	e, and due to the ca arred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
4		To the within To the Comple	Me	29b. Signature and the of contriber Affencing Physicia 29c. License number D44973	29	d. Date signed (Mont	h, Day, Year) 200 7.
		8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GURMEET 325 Hospital Drive, Suite 202, Gilen Burni		-21061	
		St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

			For State Registrar	State of Ma	ıryland		rtment of H				giene ()	7 00351	
	Physici /Medio	cal	Decedent's Name (First, Middle, La John J. Aa. Facility Name (If not institution, gingle).	Nemsey	K		4b. City, Town, or	r Location		Date of De Month	eath Day Y	7ear 3. Time of Death 757 1450 M	
	Funeral Director		Johns Hopkin 5. Social Security Number 6.3	is Geriatri		enter ast birthday) Yrs.	Baltı If Under 1 Year Months Days		Marc 24 Hrs. 8.	INVITION DE		J. Birthplace (State or Foreign Country) PA.	
	Maryland -f ahow	tor	10a. State 10b. County Maryland Baltimo	re		Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the	Funeral Directo	10e. Street and Number 10f. Zip Code				1236	10g. Citizen of What USA			,		
0-00-0	be filed within 72 hours after death with the Maryland hall tyglene. id other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, the Medical Exam actimal technified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba ☐ Yes XX No	ispanic Ori in, Mexicar Specify:		Yes or No an, etc.)		American Indian, White, etc. White	
0-61717	within 72 ho piene. r than "natur the Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 9 years	Education rade completed) College (1-4or 5-	+)	(Give I	ent's Usual Occupa kind of work done o O NOT use retired	during mos	st of working		16b. Kind of Busin	ness/Industry	
/land	2 should be filed and Mental Hyg ta marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last Jacob Niemczyk	0			=		er's Name (Fi Schnei		, Maiden Sumame)		
e, Mar	s 1 and 2 should of Health and Men Item 27 is marke other traumatic		John W. Nemseyk	(Type, Print) Son	20h Bl	6 Sha	rpley Co		Fuller	ton,	er, City or Town, Sta Maryland	21236	
Baltimor	t. Page rtment o rtant: If rjury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contr	ify)	Ce	ist Luth	ition (Name of atory or other place eran Cerrete	ery	Januar 8, 200	У 7	Dundalk,	MD.	
Da	Deparation of the control of the con		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or con	Kn	the death	71	10 Solle	rs Po	oint Ro	ad, I	Dundalk, D Dundalk,M	P.A. D. 21222 Approximate	
	Physician /Medical		shock, or heart failure. List only one cause on each line. Interval Be Onset and Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Prostate Cancer Due to (or as a consequence of):									Interval Between Onset and Death	
J	cate be executed was hysician and the burial-transit and	dical Examiner										years (1991)	
O. DOX 00	certific Iding p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							,			
cords, r	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 yes 2 yes 3 pro										
	40 51 61	Completed by	SEVERE AGRIC STENOS(S 24a. Was an autopsy performed? performed? 1 yes 2 70 1 yes										
on or vital	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No								dence 6 Other	ice 6 Other (Specify)	
DIVISION	el or Atter s after dea at Director ed in by the	Certification:	2 Accident Investigation 3 Suicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)								or Rural Route Number,		
	the Hospii in 24 hour the Funer pletely fill	edical	one)	hysician: To the best of miner: On the basis of and manner state	examınati	vledge, death on and/or inv	estigation, in my op	oinion, dea	nd place, and oth occurred a	t the time,	date and place, and	due to the cause(s)	
	with To Con	M	29b. Signature and title of certifier	772		w		number 43	95		JANUARY /		
	17		30. Name and address of person who DANIEWE DOBERM, 31. Date filed (Month, Day, Year)	ANIMD 5	5505	HOPK	INS BAN	NEW	CIRCU	E 6	BACTIMORE,	MD 21224	
	Sta Registr		JAN 1 0 2	32. Registrat	s signati	k d	ed						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day US Month Year **Physician** Hok Ling Ng January , 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner HIMOre Ciltracie Year If Under 24 Hrs. 8. Date of Birth (Mohth, Day, Year) 1/10/1955 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 214-17-2383 51 Hong Kong Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Funeral Director Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 11912 Tarragon Rd. Apt. D 21136 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: asian 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yuk Sun Ng Mei Chun Yeung ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Chung Ling Ng/brother 318 Woodbourne Ave. Baltimore, MD21212

ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1-9-2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Towson, MD21286 Cremation &Funeral Alt.8717Green Pastures 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner and Il-transit requires that the death certificate be executed burialattending physician for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 mpoutopenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has 1 page 2 certificate Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation Within 24 hours after community to the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division or Vital

Registrar

THOURS 31. Date filed (Month, Day, Year)

GENUL 32: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MI

M

D0027119

Jan, 05,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registration of Per Phy G863 1/10/OF rotation of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day JANUARY 6, 2007 **Physician** 6:30 P ANNA NADEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE 2916 MARNAT ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/26/1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Months 1 □ M 2 □ F PA 90 186-03-8807 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🕅 No BALTIMORE MD BALTIMORE Directo 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 2916 MARNAT ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify. Specify: þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) **ANDERSON** MARY **JOSEPH** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3626 ANTON FARMS ROAD - BALTIMORE, MD 21208 MARVIN MILLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH HAMEDROSH HAGODOL 1/8/2007 ROSEDALE, MD 21. Signature Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a, Part1. Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 1No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 🔲 Yes 2 ∏ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed ig physician and as the burial-transit or Vital Records, P.O. Box 68760, use been signed by the should be detached certificate has Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, Division death. after within 24 hours a To the Funeral L

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural", or

al Hygiene.

Physician /Medical

Examiner

or other traumatic event, the Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

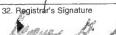
30. Name and address of person who completed cause of death (them 23a) (Type, Print) Um 31. Date filed (Month, Day,

> 0 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Pate signed (Month, Day, Year)

P.O. Box 68760. Division or Vital Records. To the Hospital or Attending Physician: nours after death.

neral Director: After this
filled in by the funeral d within 24 hours a

To the Funeral I

completely filled

m

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of centifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Home

Baltimor, MARYUND XIZZI

Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

JANUARY 08, 2007

4940 EASTERN AVENUE BALTIMORÉ, MARYLAND LAURENCE EDELMAN, M.D. Registrar's Signature

Home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🗋 🗍 🦪 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 55 26074a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ASSISTED LIVING BALTIMORE COUNTY QUAIL RUN BALTIMOVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours a Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🛠 🗙 No BALTIMORE BALTIMORE COUNTY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 9400 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1935 ~1939 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Specify Specify: XX Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U. S. Government Elementary/Secondary (0-12) College (1-4or 5+) Glen L. Martins 12 yrs. N/A Navy Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Picard Malvina Valett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila M. Porter (Daughter) 7603 Babikow Rd. Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 1-12-2007 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home ass Baltimore, Md. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place preath Check only one examiner? Hospital: 1 Inpatient 2 No Other: 1 🗌 Yes 2 ER/Outpatient ursing Home 5. Residence 6 Other (Specify) 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Examiner sicien and burial-transit The law requires that the death certificate be executed the th phy use as t ŏ P.O. | ed by the a detached f Division of Vital Records, certificete has been s rector, page 2 should has or Attending Physician: funeral director, this After s after death. the in by 1 within 24 hours a
To the Funeral I
completely filled Hospital peliil To the

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Funeral

Director

Work

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryla Inspertment of Heelth and Mentel Hygiene. Inspertment of Heelth and Mentel Hygiene. The firmportant; if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar mant be inclined at once.

Physician /Medical

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

Maryland 21215-0036

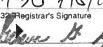
Baltimore,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of cert

30. Name and address of p



of death (Item 23a) (Type Print)

29c. License number

29d. Date signed (Month, Day, Year)

Are Belteman 17 2 122

ORIGINAL

		4	For State Registrar	State of Mary	land / D		nt of Hea	Ith and M	lental Hy	•	07	00356
	Physicia		Decedent's Name (First, Middle, Las		DT A	OPV.			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medica	ıl		JAMES	РЬА	CEK	Town or Los	ation of Death	01	05 2	2007	10:10AM
	Examine Funeral Director		212 20 0327		Cente yrs. last birtl 81 Y	er	Rose of	1 1	8. Date of Birt (Month, Day 1 - 24 -	Box	9. Birthple	ace (State or Foreign
	land	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location					10	d. Inside City Limits
	a-f sh	ctor	MD BAI	LTIMORE			ROS	EDALE				1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show	rai Director	10e. Street and Number 1240 LANDOVER		ROAD			10f. Zip Code 21237			S.A.	Α.
	or ite	by Fur	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 194			edent of Hispa ecify Cuban, N		ecify Yes or No- Rican, etc.)	Specify	k, White, e	tc.
nald 1215-0036	C 59	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a.	Decedent's Us (Give kind of w life. DO NOT OWNE]	rork doné durin use retired)	n ng most of worki	ing			,
Dor land 21	tal H d ott	lo Be Co	17. Father's Name (First, Middle, Last) SYLVAN	P	LACEK	OWNE	18.	Mother's Name	(First, Middle,	Maiden Sumam	year 2007 10:10 Am M unity of Death 2017 10:10 Am M unity of Death 2017 10:10 Am M unity of Death 2017 10:10 Am M 2017 10:10 Am M 2017 10:10 Am M 2017 10:10 Am M 2017 10:10 Am M 2017 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No 2018 10:10 Am M 2018 2 M No	
Mary S	nd 2 she lith and 27 is m r traum	-	19a. Informant's Name/Relationship (7 HARRIETT PLACE	• • • • • • • • • • • • • • • • • • • •		Mailing Addre				or, City or Town,		
$P/\alpha_{\mathcal{C}}$ Baltimore,	Page nent o nnt: If ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:	r)			. GRDN	1-10		BEL A	IR,	MD
Ba	Deporte Importa any nji				7			CO AVE		SEDALE ROSEDAI		
•	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Pulmo	nary	Ede	ma					Interval Between Onset and Death I dau
8760,	ysicie	<u>g</u>	resulting in death) Last Due to (or as a consequence of):									· · · · · · · · · · · · · · · · · · ·
Division of Vital Records, P.O. Box 68	The law requires thet the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic 5 □ Other (•
<u>s,</u>	igned be det	D P	Part II. Other significant conditions of	·			cause given in	Part I.	23e. Did to			
Sorc	been should	eted	renairante	Hypert	nyrei	aism	A '		24a. Was			
al Re	n: The lav ficate has or, page 2	Comp	Emphysema	Periph	erou v	oscu la			autop perfor 1 Tyes	2 No 1	leath?	
<u>=</u>	ysicia is certi directo	o Re	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 VInpatient	2 ER/Out	patient 3□ [Othor		n <i>Check onl</i> y o		er (Specify)	
ion o	Attending Physician: r death. ector: After this certifics by the funeral director, i	ation: 1	1 Yes 2 No 1 I Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Injury									
Divis	우충분드	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (S	oecify)				City or Tow	n, State)		
	To the Hospital within 24 hours e To the Funeral completely filled	Medical	29a. Certifier 1 V Certifying Phyone) 1 W Certifying Phyone	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, mination and	death occurre Vor investigation	d at the time, d on, in my opinio	date and place, on, death occurr	and due to the deed at the time, d	cause(s) and ma date and place, a	nner as sta and due to	ted. the cause(s)
	To the within 2 To the complet	¥ S	29b. Signature and title of certifier	26/)	2	9c. License nu	mber (21/2/		29d. Date signed	l (Month, D	ay, Year)
	10	1	30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print)	DV	1876		15/07		
	Stat	2	D 11 .	eridan MD.	9000 Signature	Frank	lin Squ	are Dr	ive, Ba	1timore	MD,	21237
	Registra		JAN 1 0 21	007 Linear	K	Book	P					

07-00166 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bryon Joseph Predika State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1 Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Deat Month Day January 6, 2007 **Medical Examiner** 1810 hrs Bryon Joseph Predika

4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3009 Pinewood Avenue Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs **Funeral** 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Months Days Foreign Director Hours 1 × M 286.34.8831 67 03.29.1939 OH Usual Residence of Decedent any 10b County 10c. City, Town or Location Od. Inside City Limits 28a-f show MD Yes 2 Baltimore once. after death with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Number Of, Zip Code 10g. Citizen of What Country 3009 Pinewood Ave. 1st. Floor 21214 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 White etc. Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify "natural", ģ Pages I and 2 should be filed within 72 hours in ment of Health and Mental Hygiene an: If item 27 is marked other than "natura or other traumatic event, the Medical Examina 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than "traumatic event, the Medical Baltimore, MD 21215-0036 unknown unknown 17 Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian Lapides/Lawyer **Hamill** Road Baltimore MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ment c Donation 5 Other Specify Chesapeake Crem. 01.09.07 | Beltsville, MD or o Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And FuneralBalto 8717 Green Pastures Dr. MD 1 IAlternatives 8717 Green Pasti Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I Enter the disease, or complications **Physician** Approximate Interva failure. List only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical sician burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, tending physuse as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No No 25. Was case referred to medical 26 Place of Death (Check only one Be Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural 5 Pending Yes 2 No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number City 3 Could not be Suicide or Town, State) Homicide 29a Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician; To the !

DHMH 17 Rev 1/200 OCME 2006

State

Registra

ORIGINAL

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Redistrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 7, 2007

and manner stated

mp

30. Name and address of person who completed cause of death (Item 23a)

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

			for State Registrar	State	of Marylan	•	rtment of F	lealth and N Death	, ,	iene	17	00358
M.	Physici	an	1. Decedent's Name (First, Middle						2. Date of Deat	h	near	7:50 PM
	/Medic	cal	Paul A. Papayar 4a. Facility Name (If not institution		imher)		4h City Town o	r Location of Death				М
	Examin	ier	Holy Cross Hos		arriber)		46. City, Town, o	Silver Sp	ring	4c. County o	mer	Y
	Funeral Director		5. Social Security Number 214–38–5666	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (12/14, 23/1	№926	9 Birthr Græe	place (State or Foreign
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	e Mary a-f sho	ţċ					Wash:	ington DO				12©Yes 2 □ No
	3a or 28	I Dire	10e. Street and Number 901 6th St. SW	#215			10f. Zip Code 20024-		og. Citizen of Wi United	hat Cour Stat	ntry? .es	
036	be filed within 72 hours after death with the Marylan at all tygiene. At the William of other than "natural", or Items 23a or 28a-f show or other the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1Æ Never Married 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 No ive	1	Vas Decedent of H f Yes, specify Cuba	Ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-		White	can Indian, etc. Le
9500-61212	I within 72 ho jiene. r than "natui th Medical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed, College) (1-4or 5+)	16a. Deced (Give life. L Print		ation during most of work d)	king	Pubi isk	ing	dustry
yland	uld be filed Mental Hyg Irked other Itic event, 1	To Be C	17. Father's Name (First, Middle, Anastasio Papa	Last) ayannis				18. Mother's Nam Theodora	e (First, Middle, M Papavin	faiden Surname	,)	
Mary nd 2 sho	s 1 and 2 should f Health and Men item 27 is marke other traumatic	6	19a. Informant's Name/Relations Stephanie J. Gr	hip <i>(Type. Print)</i> ogan/Guard	lian	19b. Mailin 5907	g Address <i>(Street a</i> Massach)	and Number or Ru isetts Av	ral Route Number Bethe	Sda, Mo	ita '2 0'8	16 €
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		State 20b. F	emetery, cren esapea		fory Inc.			City or To	wn, State Maryland
ם	permit. Depart Import any Inj once.	<u></u>	21. Signature of Funeral Service	Licensee	m1358	28	app Flader 33 Gist A	alf FaciliQrem ve. Silv	ation Server Spring	vices , Maryla	nd 2	0910-
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Sepsian Sepsian Sepsian Sepsian Sepsian Sepsian as a sepsian sep									
	Examiner	Ļ	Due to (or as a consequence of): Pneumonia b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Days
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):								
00/00°	ficate be executed physician and is the burial-transit	dical Exa	resulting in death) Last	Due to	(or as a consequ	uence of):						
oo X	sertifica ding ph se as th	Med	IF FEMALE:	220 H ven ev	stoome of average	-						
.O. Box	the death certif y the attending iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	atcome pf pregnation birth 2 □ Feta nant at time of decomposition of decomposition birth	Ideath 3□	Ectopic pregnancy Other <i>(specify)</i>			23d. Date Mont		ery Day Year
ecords, P	requires that the een signed by th hould be detache	by	Part II. Other significant condition	ons contributing to o	death but not resu	ulting in the un	derlying cause give	en in Part I.				ne cause of death?
nec L	The law te has b	Completed							24a. Was an autopsy perform	/ pri led? de	ere auto ior to con ath?]Yes	psy findings available inpletion of cause of 2 No
<u> </u>	sician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			3 DOA Othe	or.	h (Check only one)		
5	ig Physter this neral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of Injury	3 DOA 28c. Injur	4 Nursing Ho	ome 5 ☐ Resider 28d. Describe hov			y)
202	tendin leath. tor: Af the fur	catio	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation			M 1□	Yes 2 □ No				
5	al or A	Certification:	4 Homicide determ	ined Zoe. Flac	e of injury - At ho ling, etc. <i>(Specif</i>)	ome, farm, stre	et, factory, office		28f. Location (Str. City or Town,		or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; p	Medical (29a. Certifier (Check only one) Certifyir 2 Medical	g Physician: To the Examiner: On the l and mar	e best of my kno basis of examina oner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occu	and due to the ca	use(s) and man	ner as si	ated. the cause(s)
)	To t To tl	M	29b. Signature and little of certifie	wee	MS		29c. License D3	number 2332	29	d. Date signed (
	6		30. Name and address of person Suresh K. Gup					pring MD	20902			
	Sta Registr	_	31. Date filed (Month, Day, Year)	0 2007	Registrar's Signa	ture	price					

			_ FOI	epartment of Health and No	Mental Hygie	7001	00359			
	Physici		1. Decedent's Name (First, Middle, Last) Virginia Parker		2. Date of Death Month January	Day Year 07 2007	3. Time of Death 9:25 A ^M			
•	/Medic Examin		4a. Facility Name (If not institution, give street and number) Ritchie Hospice	4b. City, Town, or Location of Death Baltimore		4c. County of De	ath 'A			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birth 80 Yi	Months Dave Hours Min	June 10	1936 ^{9. 8}	irthplace (State or Foreign Country) MD			
	ryland thow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	r 28a-1 s	irecto	Maryland Anne Arundel 10e. Street and Number	Brooklyn Pa		. Citizen of What (
	eeth witt	eral D	5 Coach Lane 11. Marrital Status 12. Was Decedent Ever in U.S.	21260	pecify Yes or No-	USA 14. Race - An	nencan Indian,			
036	filed within 72 hours after deeth with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f ahow ant, the Medical Examinat must be notified at	Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married I Yes 2 No II Yes 2 No II Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerlin 1 ☐ Yes 2 ☐ No Specify:	o Rican, etc.)	Black, Wh	white White			
Maryland 21215-0036	hin 72 ho 9. An "natur Medical	pleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	king 16t	b. Kind of Busines	s/Industry			
d 21	filed wit Hygiene other tha	e Con	5 17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Nam	ne (First, Middle, Mai	Househo	old			
<u> </u>	hould be d Mental marked matic ev	To Be	Herbert Brune 19a. Informant's Name/Relationship (Type, Print) 19b. 19b. 19b. 19b. 19b. 19b. 19b. 19b.	Anna Aailing Address (Street and Number or Ru	Virginia					
Z	and 2 s lealth an m 27 is i		Linda Leymaster (daughter) 5	Coach Lane, Brookl	vo Park. N	D 21260				
Baltimore.	Pages 1 nent of H int: if ite		1 XBurial 2 Cremation 3 Removal from State	crematory or other place) 3 ven Cemetery 20		c. Location - City o Len Burni	e, Maryland			
Balti	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, important: if I tem 27 is marked other than "n any injury or other traumatic event, It a Med once.		21. Signature of Funeral Service Lic ns	22. Name and Address of Facility 3111 Mountain Roa	Stallings d, Pasaden	Funeral	Home, P.A. 122			
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failbre. List only one clause on each line. Immediate Cause (Final disease or condition				Approximate interval Between Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of	:			1101			
3	pe 14. #5	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:						
7:25a	cate be executed physicien end the burial-transit	icai Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):							
687	ortificate ing physi e es the t		IF FEMALE:	_		I				
57 0. Box	he de the a	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of d Month	elivery Day Year			
Lt Sp.	w requires that the bear signed by should be detact	Ď	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.			to the cause of death? Probably 4 ⊟Unknown			
Recor	The law resete has bee	Completed			24a. Was an autopsy performed	d? prior t				
arkey	ysician: is certifica director,	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Other	ome 5 Residence	/	market to source			
0	_ = 6		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inj		28d. Describe how		They is			
raina Division	i or Attending efter death. Director: Afte d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Coult not be det mined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S		Rural Route Number,			
5	To the Hospitel or Att within 24 hours effer d To the Funeral Direct completely filled in by	dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination and and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)			
	To the Hosi within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mo	nth, Day, Year)			
	6		30. N me and a dress of purson who is impleted cause of weath (Item 23a) if	ype, Priju	B-121	11/0	ninia			
	Sta		31. Date filed (Month, Day Year) 32 Registrar's Signature	rung na	DINTUS)	1111	1/1/5			
	Regist	rar	JAN 1 0 2007 Same &	Secretary and the secretary an						

,	Ter State of Marylar Registrar	nd / Department of Certificate of		Hygiene Reg. No.∕ ∩	07 0000		
cian	1. Decedent's Name (First, Middle, Last) Charles Clifton Quick		Mor	of Death	Year 07 11:05 AM		
dical niner	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice	Timo	or Location of Death	4c. County Bal			
al or	5. Social Security Number 216-34-5847 Usual Residence of Decedent 6. Sex 1 M 2 F 69	Yrs. If Under 1 Year Months Days	Hours Min. (Mo.	e of Birth nth, <i>Day</i> , <i>Year</i>) 15, 1937	9. Birthplace (State or Fore Country) Maryland		
ctor	7	ty, Town or Location Baltimore			10d. Inside City Lim		
Director	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Country?		
To Be Completed by Funeral Director	4202 LaSalle Road 11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	.S. 13. Was Decedent of If Yes, specify Cul	206 Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e				
leted by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 155— 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu			white		
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	supervisor		mainte			
To Be	17. Father's Name (First, Middle, Last) Edward Charles Quick		18. Mother's Name (First, and Mary Magda)		,		
	19a. Informant's Name/Relationship (Type. Print) Barbara A. Scott/daughter		t and Number or Rural Route		State, Zip Code)		
		Place of Disposition (Name of cemetery, crematory or other pla	Date	20c. Location -	City or Town, State		
ouce.	21. Skind for a Euneral Service Licensee Ronal of S. Wade, hitesto:		omy Board 655 MD 21201	W. Baltim	ore Street		
dical Examiner	Immediate ause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LUNG CANCER Due to (or as a consect of the condition of the consect of	quence of):			Onset and Death		
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of co	al death 3 □Ectopic pregnan	у	1	23d. Date of delivery Month Day Year		
þ	Part II. Other significant conditions contributing to death but not res	ribute to the cause of death					
Completed				autopsy performed?	Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No		
ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Accident Services Accident (Month, Day Year)	28b. Time of Injury 28c. Injury			er (Specify) HOSPIC		
l Certification:	action in a CCC could not be		City	or Town, State)	per or Rural Route Number,		
Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or investigation, in my	opinion, death occurred at the	e time, date and place,	and due to the cause(s)		
2	29b. Signature and title of certifier	29C. Licen	~372j	29d. Date signe	d (Month, Day, Year)		
	30. Name and address of person who completed cause of death (Iter DR. TARIO MAHMOOD 2300 DULANE 31. Date filed (Month, Day, Year) 32, Registrar's Signary	Y VALLEY RD.	CIMONIUM, MD 3	21093			

DHMH 17 Rev 1/2001

CHARLES CLIFTON QUICK
Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

11:05 a.m.

JANUARY 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

				State of Manua				-	_	
			For State	State of Maryla				nentai Hygie	ene 2007	00361
			Registrar		Ce	ertificate o	T Death		. No (U U /	00301
	Physici	an	Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Judy Kirsch Ro					January	7, 2007	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death		4c. County of Dea	
			Upper Chesapeak		en lage high da		el Air ar If Under 24 Hrs.	9 Date of Birth	Harfo	
	Funeral		5. Social Security Number 6. S	65 1 Age (in y.	rs. last birthdaj Yrs.	Months Day		8. Date of Birth (Month, Day,) July 19,	(ear) 9. Br	thplace (State or Foreign ountry) State
	Director	}	533-42-2483 Usual Residence of Decedent	05				July 19,	1941 W	ashington
	land ow		10a. State 10b. County	10c.	City, Town or I	ocation				10d. Inside City Limits
	Mary ah	ţ	Maryland Harf	ord		Forest	H-111			1 ☐ Yes 2 X ☐ No
	hours after death with the Maryland tural', or Itema 23a or 28a-f ahow al Examinamental be nutified at	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
	3a o		214 Marshall Dri	ve			21050		U.S.	Α.
	ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13	. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ami	erican Indian,
9	after or its	Ē	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 X Yes 2 No If Yes, Give 19	962-	1 ☐ Yes 2K N		Hican, etc.)	Black, Whi	te, etc.
93	ral', c	ρ	3 Widowed 4 Divorced	Year or Dates: 10	963	T Tes ZAIN	lo Specify:		Specify:	Vhite
5-0	72 hc	Completed	15. Decedent's E. (Specify only highest gra		16a. Dec	edent's Usual Occ	cupation ne during most of work	sina 16	6b. Kind of Business	/Industry
50	within 72 ane. than "na	du	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use ret	ired)		Food Spec	alty
42	ygjer ygjer t.	Ö		2 Years		Admini	strative		Busine	SS
2	be fill d oth	Be	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Z S	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itema 23s or 28s-1 show aumstic avent, the Madical Examinat must be nutified at	၉	Al Pitts					tty Pitts		
Mar	s 1 end 2 should I Health and Men Item 27 is marke other traumatic	1	19a. Informant's Name/Relationship (1		et and Number or Rui			
C 6	end lealth m 27 her t	į	Ronald K. Rose, S			Marshall Dosition (Name of	Dr., Fore			
0 0	Pages 1 nent of H int: If Ite	1	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	cemetery, cr	ematory or other p	place)		Oc. Location - City or	
LI	Pa men tant: Jury		4 □ Donation 5 □ Other (Specific	**	-	Cremato				Maryland
1 フ (0 フ 1 9 ユ g Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 Department of Heatth a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service Licer	nsee						e of BelAir
	907 g a		23a Part1. Enter the disease, or com				0 W. Macph			Md. 21014 Approximate
	Physician /Medical Examiner pe prijetravsit pe prijetravsit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cons	requerice of):	Coldis				Interval Between Onset and Death
2463 .0. Box 68760,	death certificete e ettending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	_d	etal death 3	□Ectopic pregna □ Other (specify)			23d. Date of de Month	livery Day Year
COUT rds, F	juires tha n signed i ild be det	þ	Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause	given in Part I.	23e. Did toba 1 ☐ Yes		o the cause of death?
Moocy al Record	hysician: The law requires that the his certificate hes been signed by the director, page 2 should be detache	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
- ##	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:		1.	Othor	th (Check only one)		
35	Physic this all dir	မ	1 Yes 2 No	1 Ja Inpatient 2		BIIL JUDON			ce 6 □Other (Spe	acify)
万章	ing After	<u>o</u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury		njury at Vork?	28d. Describe how	injury occurred	
1 7:5		cat	2 Accident investigation 3 Suicide 6 Could not b		A 5		☐ Yes 2 ☐ No	294 Lanation (Cton		
S.S.	o age c	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		street, factory, offic	ce	City or Town,	et and Number or A State)	urai Houle Number,
000	Hospitel or 24 hours efte Funaral Dir staly filled in		29a. Certifier 1 Certifying Pt	nysician: To the best of my l	knowledge de	ath coourad at the	time date and place	and due to the cau	150/5) and manage	
2	24 hc 24 hc Fun etaly	Medical	(Check only 2 Medical Exar	niner: On the basis of exam and manner stated.	ination and/or	investigation, in m	y opinion, death occur	red at the time, date	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	ense number	290	d. Date signed (Mon	th, Day, Year)
	+ 3 F 8		· ale	MD		7	00632	20	108/20	
	2		30. Name and address of person who	completed cause of death //	tem 23a) (Tvo		long T	CORDA	115	
	1		500 MPPER	CHESAPEAN	(£)	R, BEE	ATD 1	1 D 2/0	14	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	6	1111		', [
	Registr		JAN 1 0	2007	A.	parks				

07-00126 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kimberly Ann Rollison State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day January 5, 2007 1142 hrs **Medical Examiner** Kimberly Ann Rollison 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death 120 Sloane Drive Apartment A Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or Age (In yrs, last birthday **Funeral** Days Min Months Hours Director c Pennsylvania Feb. 23, 1966 40 169-64-0946 M 2X F Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show Glen Burnie Maryland Anne Arundel es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g Citizen of What Country United States 120 Sloane Drive, Apt. A 23a Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: White Widowed Divorced Yes. Give Year Yes 2 X No specify: \$ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Not Self Supporting Dependant 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) event, t Be Swingle Rollison Glenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 27 Prompton, Pennsylvania 18456 158 Church Street, Debra Merritt, Sister item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 Removal from State West Arundel Crematory Jan. 10,20**0**7 Odenton, Maryland Important: injury or oth ment Other Specify: Donation 5 nätur of Funeral S rvice Licenses 22. Name and Address of Facility Jenkins Funeral Home 17 269 Belmont Street, Waymart, PA 18472 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Oxycodone, methadone and venlafaxine intoxication Approximate Interval **Physician** Retween Onset and /Medical Death Orycodono and methodone intovication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of Sequentially list conditions Dus to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical #23a,perM,E g863, 1/24/0/ TI X UNPENDED AMENDED #23a,27,28a-f, perME, g863, 1/23/07 TT Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by 23c If yes, outcome of pregnancy 23d Date of delivery phy the 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months Pregnant at time of death Other (Specify) Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 2 No Yes certific 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital 1 Other₄ examiner? Nursing Home 5 Residence 6 Other Scene Inpatient 2 DOA ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury occurred Certification Natural 5 Pending Yes 2X No To the Funeral Director: completely filled in by the 24 hours after death Fnd 1/5/2007 Fnd 9:17 am unknown 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 120 Sloan Dr. Apt. A clen Burnie, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined Homicide found at residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only

State

Registrar

29b Signature and title of certi;

Mary Q. Ripple MD.

ddress of person who completed cause of death (Item 23a)

2007

Deputy Chief Medical Examiner

Registrar's Signatu

DHMH 17 Rev 1/2001 OCME 2006

2 Wedical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State of M	arylanu		artment of i rtificate of			Reg.	Em () () 1	00303
	Dharisi		1. Decedent's Name (First, Middle,	•	-					Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Everett O. Rh							inuary "	7 2007	8145PM
7	Examin	er	4a. Facility Name (If not institution,	1 1 1 1	1 0	. i	4b. City, Town,	or Location			4c. County of Deat	unda I
			5. Social Security Number 6		ge (In yrs. las	t birthday)	If Under 1 Year		124 Hrs. 8. [Date of Birth Month, Day, Ye		thplace (State or Foreign
	Funeral Director		236-18-7413 Usual Residence of Decedent	1 X M 2□ F	86	Yrs.	Months Days	Hours	Min. Ma	Month, Day, Ye y 12, 1	920 West	t Virginia
	aryland show		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	the Maryla 28a-f shoo	ctor	Maryland Anne A	rundel	Gl	.en Bu	rnie					1 ☐ Yes 2 XNo
	5 9 6	Olre	10e. Street and Number		_		10f. Zip Code				Citizen of What Co	ountry?
3	s 23a	rai	7885 Gordon Cour	t, Apt. 53		12		060	rigin? (Specify		USA 14. Race - Ame	arican Indian
-0036	or ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Forces	?	1	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2X No			in, etc.)	Black, Whit	
20	C4 @ U	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occu kind of work done	during mo:	st of working	161	o. Kind of Business	/Industry
₹ <u>₩</u>	be filed within 72 ital Hygiene. d other than "natewent, tre Minicolar	ш	Elementary/Secondary (0-12)	College (1-4or			DO NOT use retire	ed)		3.0	£	
10 kg	filed v Hygie other t	Co	17. Father's Name (First, Middle, La	0 (st)		Welde	er	18. Moth	ner's Name (Fi	rst, Middle, Mai	fg. den Sumame)	
Maryland 2121		To Be	Charles Oley Rho					Len	na Wayb	right.		
ary	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationshi			19b. Maili	ng Address (Stree	-			ity or Town, State,	Zip Code)
	1 and 2 s Health ar tem 27 is		Phyllis Love / I	aughter							land 2179	
ore	es 1 and of Healtl if item 27 rr other 1		20a. Method of Disposition 1 Burial 2 Cremation	f⊠Removal from State	20b. Pla	netery, crea	osition (Name of matory or other pla		Date		c. Location - City or	
Ĕ	Pag ment ant: i		`4 □Donation 5 □Other (Spe	cify)	Haz		od Cemete					West Va.
Baltimore,	permit. Pages 1 Department of H Important: If Itel any Injury or ott		21 Signature of Funeral Service Li	sensee Side							eral Home ore, Mary	e, Inc. rland 21229
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause	ed the death. line.	Do not en	ter the mode of dy	ing, such a	s cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician	H	Immediate Cause (Final disease or condition	-a Lef	+ N	817	ov r	BE	bu	mes	sino	Oriset and Death
	/Medical Examiner		resulting in death)		s a conseque	ence of):	22		1	TOTAL LINE		
		<u>-</u>	Sequentially list nonaltions if any leading to immediate	b. Chron	s a conseque	ence of):	JP17m	OW	ne 1	7	128078	
y	uted J ansit	Examiner	Secuentially list nonations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
,	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or a	s a conseque	ence of):						
68760,	cate be physicial the bu	edical		d								
	artifica ing ph e as ti		IF FEMALE:									
O. Box	Attending Physician: The law requires that the death certificate be executed riceath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/A	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal o	death 3	⊒Ectopic pregnan ⊒ Other (s <i>pecify</i>)	су			23d. Date of de Month	livery Day Year
P.O.	that the the the the the the the the the th	y Ph	Part II. Other significant condition	s contributing to death	but not result	ting in the u	ınderiying cause g	ven in Part	11.	23e. Did tobac	co use contribute to	o the cause of death?
rds	quires n sign ald be									1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown
Ö	aw requir s been si s should	Completed								24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Re	The lav	mo								performed	d? death?	
ita	i ician : Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						ce of Death (C	heck only one)		
) t	Physic this ce al direc	ို	1 ☐ Yes 2√2 No	Hospital: 1 Inpat			nt 3 DOA				e 6 □Other (Spe	ecify)
טע	tending Physician: The leath. tor: After this certificate hatte funeral director, page	iuo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury <i>ay Year)</i>	28b. Time o Injury	W	ork?		. Describe how	injury occurred	
Sio	death.ctor: /	icati	2 Accident investiga 3 Suicide 6 Could no	t be 390 Place of I	niunz - At hon	ne farm st	M 1 [Yes 2[Location (Stree	nt and Number or R	ural Route Number,
Division of Vital Records,	or A efter o	Certification:	4 Homicide determin	building,	etc. (Specify)	no, iaiii, st	reet, ractory, office	,	2011	City or Town, S	State)	
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	ledical Co	29a. Certifier 1 X Certifying (Check only one) 2 Medical E	Physician: To the bes xeminar: On the basis and manner s	of my know	rledge, deal on and/or in	th occurred at the evestigation, in my	time, date a opinion, de	and place, and eath occurred a	due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	o the ithin of the omple	Me	29b. Signature and title of certifier				29c. Licer	nse number	r	29d.	Date signed (Mon	th, Day, Year)
	► < ⊢ ŏ		O M	0	mo		0	637	-24	01	, 07. 2	ron
	2		30. Name and address of person w	ho completed cause of			Print) 3×	1 1	riot	1782	, 05'S	INE
	.)		MAJERON	Imnu	Kmr	m.	1 01	してか	B	Moser	IE M	100E C
I	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 0 2007		trar's Signatu	en.	٧					*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:00 P M /Medical Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Bettima Balto 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Numb **Funeral** Days Months Hours Min. 1 ☐ M 2 🖫 F 212-60-9571 Director 08/11/1953 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23e or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23e or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. MD 1 X Yes 2 □ No Be Completed by Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 2822 Harlem Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2 f Yes, Give rear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No SpecifAfrican American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Direct Care Assistant Rosewood State Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Rice Paul Rice 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4629 Coleherne Road; Baltimore, Maryland 21228 Sharon Y. Rice / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/15/2007 Western Star Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse a each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter in the past 12 months
1 ☐ Yes 2 ☐ Yo Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2010 2 PLM 1□ Yes 1 ☐ Yes 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 10 1 Hopatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: death the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and ad s Signature 31. Date filed (Mo nth, Day, Year) 32. Degistra State JAN 1 Registrar 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5,2007 0056M Beverly Lee Skurzynski January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Aut

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Mau 20, 1936 Upper Chesapeake Medical Campus Harkord 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F 70 213-32-9252 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehov my injury or other treumatic event, the Medical Examiner must be notified at 905a. 1 ☐ Yes 2 No Maryland Harford Abingdon Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 U.S.A. 3406 Henry Harford Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Stella Maris Hospice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Esther Bertling Clarence E. Garu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Henry Harford Drive, Abingdon, MD 21009 Bonita L. Montalvo (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/9/2007 Baltimore. Maryland Gardens of Faith 4 □ Donation 5 □ Other (Specify) 21. Sunature of Funeral Service Livenage 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) ELECTRO MAGNETIC DISSUCIATION Physician /Medical Due to (or as a consequence of):

UROSEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner SYSTEMIC INFLAMMATORY RESPONSE Due to (or as a consequence of): P.O. Box 68760 COLL CARCINOMA OF LUNG WITH METOSTASIS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknows 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 AN USHA SIRITHARA, 2112 BELAIN ROAD, SUITE 10, FAUSTON, MD 21047 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

ORIGINAL

DHMH 17 Rev 1/2001

大ファイント

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma		partment of Fertificate of		lental Hygier	6001	00366
	Physici		1. Decedent's Name (First, Middle, Last) Mary Bernadette Strohm	er			2. Date of Death Month	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death	-	c. County of Deat	
				Ospital		echole		Balti	MORE
	Funeral Director			(In yrs. last birthda) 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 13,	Q Riet	hplace (State or Foreign untry) WYULAND
			Usual Residence of Decedent				Sept. 13,	171φ Μ	aryxana
	ryland	_	10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits
	he Ma	Director	Maryland Baltimore		Baltimo	re	10-1	200	1 ☐ Yes 2 No
4	uth with the Marylan 23a or 28a-f show ust be notified at	i Dir	10e. Street and Number 4109 Glen Park Road		10f. Zip Code	21236	10g. C	Citizen of What Co U.S.A	•
7	er death with the Maryland Iteme 23s or 28s-1 show Itematibe matified at	nera	11 Marital Status 12. Was Decedent E	Ever in U.S. 13	. Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
\$ 8	or its	y Fu	1 Never Married 2 Married 1 Yes 2 N If Yes, Give		1 ☐ Yes 2 No		nican, etc.)	Black, Whit	
F-0036	filed within 72 hours after Hygiene. Hyper then "natural", or ite int, the Wedical Examilie	Completed by Funeral	3 ₩ Widowed 4 □ Divorced Year or Dates:	16a, Dec	edent's Usual Occup	pation	16b	Kind of Business	ite
~ I	hin 72 l	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Giv	e kind of work done DO NOT use retire	during most of workind)	ing		
15 K	be filed withing the Majore.	Com	3	Н	omemaker	Ţ		Own Hom	e
√ 1 and	a a b	Be	17. Father's Name (First, Middle, Last) (Names Unknown)			18. Mother's Name	e (First, Middle, Maid N. Warwi.c		
ROHME.	2 should and Men is marks aumatic	To	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ling Address (Street		al Route Number, City		Zip Code)
Z Ž	5 6 6 5		Paul G. Strohmer (son)	410	9 Glen Pa	rk Road, 1	Baltimore,	MD 2123	6
S+.	00		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State		ematory or other pla	сө)		Location - City or	
() Ē	Pa nen ant:		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee			Cem. 1/11/	12007 Ba imunek Fun		Maryland
Ba	permit. Departr Imports eny Inje	ļ,	21. Styllating Stright all Service Ligation				anuner run altimore,		
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	the death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a consequence of):	$\overline{\mathbf{n}}$	•	·		11370
	Examiner	-	Sequentially list conditions, if any leading to immediate	a consequence of):	Meun	nonia			
	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,					
000	sate be executed hysicien and the burial-transit	Ex	resulting in death) Last Due to (or as a	a consequence of);		···			
38760.	sate shys	dicai	d						
Box 6	eath certific ettending p	n/Me	IF FEMALE: 23c. If yes, outcome of the control of t		OF			23d. Date of de	ivery
B	ne death the ette hed for	Completed by Physician/Me	in the past 12 months? 1 Yes 2 WNo 9 Unknown		☐Ectopic pregnancy ☐ Other (specify) _	у		Month	Day Year
Division of Vital Records. P.O.	es that the digned by the be detached	y Ph	Part II. Other significant conditions contributing to death but	It not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	v requires been sign should be	ed p	C. aiff sepsis				1 Yes	2□No 3□Pr	obably 4 🖺 Unknown
000	taw rec as bee 2 shou	plet	•				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u> </u>	: The cate had pege	Con					performed 1 Yes 2 1	death? No 1 ☐ Yes	21 No
V Its	sicien:] certificat rector, p	Be	25. Was case referred to medical examiner? Hospital:		ont aCIDOA Ott	ner	(Check only one)		
ō	ding Phys h. After this funeral di	n; To	1 ☐ Yes 2 ② No 1 ☐ Inpatier 27. Magner of Death 28a. Date of Injur 1 ② Natural 5 ☐ Pending (Month, Day		of 28c. Injur	4 Nursing Ho	me 5 Residence 28d. Describe how in		city)
<u></u>	ttending death. ctor: Aft / the fun	atio	2 Accident investigation	Year) Injury		rk?]Yes 2□No			
Ņ.	of or Attence efter death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inju	iry - At home, farm, s c. (Specify)	street, factory, office		28f. Location (Street City or Town, Sta	and Number or Ri ite)	ıral Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours efter death certificate has been signed by the ettending profite or mpletely filled in by the funeral director. page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, de	ath occurred at the til	me, date and place,	and due to the cause	(s) and manner as	stated.
	the Ho hin 24 the Fu hpletely	Medical	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and/or ted.					
	of of o	2	29b. Signature and title of certifier	1D	29c. Licens	: VVVVV	29d. I	Date signed (Mont) 8 , 200	
	(T		30. Name and address of person who completed cause of de	eath (Item 23a (T-ne	e, Print	00000		, , , ,	
	9		Dr. Kenneth J. Fado	14 900)-Frank	Jin Jua	re Drivi	e Balt	0. MD 21237
	Sta	te	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	6.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Year SHIVERS **Physician** 13:54 M JANUARY 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARAOR BAUTMORE HOSPITAL BALTIMORS 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Year) Pec. 4, 1918 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗹 F 219-20-8352 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f show any injury or other traumatic event, the Modical Examiner manks on notified an once. 1 Tes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 4642 21229 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married □Yes 2□Mo 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SelF Homema 70 ker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rokeby Davy When besste B. 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Se 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final NFECTIOUS COLITIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Directo for as a consequence off Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑No Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 2 No 1 🗌 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manne Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

RAVITET

JAN 1 0

31. Date filed (Month, Day, Year)

ORIGINAL

MARCE

HANOVER ST

3001

32 Registrar's Signature

K HW KHN

2007

BACTIMULS MD 2122)

0	0	3	6	8

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of I rtificate of	Health and I Death		iene UU/	UUJbb
	Physic		Decedent's Name (First, Middle, M. Leona Schil					2. Date of Death Month January 7	Day Year	3. Time of Death 7:15 AM M
	/Medi Examir		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Death	1	4c. County of Dea	
	_xuiiiii		Charlestown Care Ca	nter		Catonsvi	lle		Baltimor	e
	Funeral Director			1 M 2 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 6 1		hplace (State or Foreign juntry) impre, Mary Land
	D		216 20 9737 Usual Residence of Decedent	x \ 88				7441103		
	ehow	5	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	ecto	Maryland Baltimor	e	Catonsville	10f. Zip Code		1/	g. Citizen of What Co	^
	with	ā	713 Maiden Choice I	ane Room 234		21228			USA	army :
٥	4 within 72 hours after deeth with the Maryland jiene. r than "naturel", or iteme 23a or 28a-f ehow the Madical Examinar must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent E Armed Forces? 1 Yes 2 XN	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
3	irel', c	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify: W	nite
215-0036	netu	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occu kind of work done	during most of wor	king	6b. Kind of Business	Industry
717	withlir ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 54	Housew	DO NOT use retire ri.fe	, (i)	I	busekeeping-	Own Hame
	filed Hygi ther	Be Co	17. Father's Name (First, Middle, La		1		18. Mother's Nam	ne (First, Middle, N		·
yıand	v	To B	John H Otto				Adaline	Unknown		
Mary	2 should and Men is marke	-	19a. Informant's Name/Relationshi			-			City or Town, State,	Zip Code)
e) ∑	is 1 and 2 should of Health and Mer item 27 is mark other traumatic		Adaline Blucher	(Sister)		_	rive Balti	-		
altimore	0 0		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			matory or other pla	·	1655	Poc. Location - City or Baltimore,	
gall	permit. Pag Department Importent: f eny injury o		21. Signature of Funeral Service Li	censee		2. Name and Address	ess of Facility eral Home I	inc		
	202 • d		23a. Part1. Enter the disease, o	1880W	100				and 24236	Approximate
			shock, or heart failure. List of	nly one cause on each line	9.	er the mode of dyl	ing, such as cardiac	or respiratory arre	SI,	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	CHOIL				Week
68/60,	certificate be executed ding physician and ise as the burial-transit	cai	resulting in death) Last		consequence of):					
.c. gox	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy .		23d. Date of del Month	ivery Day Year
, , T	s that med to e deta	by PI	Part II. Other significant condition	s contributing to death bu	t not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	requires sen sign hould be	ed t	Parkinson	e discos	3C			1 □ Ye	s 2∏No 3∏Pr	obably 4 Unknown
II Records	The lay ete hes page 2	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
VItal	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		l Ott	hon .	th Check only one	-	
on or	ding Phys h. After this funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of Injury (Month, Day		f 28c. tnju	4 Nursing H	ome 5 Reside	nce 6 Other (Spe w injury occurred	cify)
DIVISION	i Diff	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 280 Place of Injur	ry - At home, farm, sti (Specify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Re State)	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	28a Cariffier 1 Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner stat	examination and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	and due to the ca rred at the time, da	use(s) and mannar as te and place, and due	stated. to the cause(s)
0	To the To the Comp	Σ	29b. Signature and title of certifier				se number		d. Date signed (Mont	*
	6	1	30. Name and address of person w	no completed cause of de	ath (Item 23a) (Type,	Print)	- 1		an 07 Cathansv	
			31. Date illed (Month, Day, Year)	Dertar M 32. Registra	D 711	Mouble	n Choic	ce Ln (ididnsv	111/2
	St: Regist	ate rar	31. Date fied (Month, Day, Year)	32. Hegistral	s signature					
DHI	MH 17 Rev 1/2		JANTO	2007 Blocus	J. M. A.	and I				
			TO BEE WAS W	1-000	ORIGI	NAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jan 6, 2007 Year **Physician** 5:00 P M Saltzman Edward Bennett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **∑**M 2 ☐ F 69 577 52 6856 1937 Director Maryland 14, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Show "natural", or items 23a or 28a-f shoved and Examiner must be notified at 1 □ Yes 2 □ No Director Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 United States 9114 Grandhaven Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1√√Yes 2 No MYes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify Specify: White þ 3√ Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Police Officer Metropolitan Police Department permit, Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If Item 27 is marked other tany Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward K. Saltzman Loretta Simons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Herbert Ave, Sangus, MA 01906 Sherri Talbott (Daughter) 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Jan 11, Date 2007 20c. Location - City or Town, State Resurrection Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral

Alexandria Ferry Road, Clint

23a. Part I. Buler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Immediate Cause (Final disease or condition resulting in death) CONG BTIVE 1+ GART **Physician** FAILURE Lawoth /Medical Due to (or as a consequence of): Examiner CAR DIOMY OF ATHY Y EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit ARTERY DESCAME CUNUWARY Due to (or as a consequence of) physician Physician/Medical the as for use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à REWAL ZNDSTA GE 1 ☐ Yes 2 ☐ YNo 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 certificate has 1∏ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes ▼ 🕅 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Division or Vital Records, .al or Atter...
.urs after death.
.neral Director: A' within 24 hours at To the Funeral D

Saltimore, Maryland 21215-0036

10+1

State Registra

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

0051437

ANNAPOLIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

OKEOWO DARCY 31. Date filed (Month, Day, Year)

JAN 1 0 2007

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial-it
To the Hospital or Attending Physician; within 24 hours after death.	To the Funeral Director: After this certifica completely filled in by the funeral director, p

an	Registrar						Reg. No.—		
al	1. Decedent's Name (First, Middle, La Helen Catheri	,	poulos			2. Date of De Month 0 1 (oth Day	2007	3. Time of Dea 4:56 a
er	4a. Facility Name (If not institution, gi			4b. City, Town, or Loca	ation of Death		4c. Co	ounty of Deatl	
	2944 Cornwall 1	Rd.	_	Dundalk			Ba1	Ltimor	re .
		4 17 14 March	(In yrs. last birth	Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birl (Month, Da	h y, Year)	9. Birth	hplace (State or For untry)
	217-24-0203	ILIM ZEEF	7 8 Y	rs.		8-10-1	1928		yland
-	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town	or Location					10d. Inside City Li
7	MD Baltin	i						1 ☐ Yes 2	
ect		liore	Dunda		Zin Code				<u> </u>
5	10e. Street and Number 2944 Cornwall	Rd.		10f. Zip Code 21222			USA	n of What Co	untry?
era	44 14 14 10 1	12. Was Decedent E	vor in II S		in Origin? (Spa	if. Voc or No		. Race - Amer	rican Indian
Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		 Was Decedent of Hispan If Yes, specify Cuban, Me 	exican, Puerto F	Rican, etc.)	. 14	Black, White	
by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Spe	ecify:		Si	pecify: wh	nite
9	15. Decedent's E		16a. D	Decedent's Usual Occupation			16b. Kind	of Business/I	Industry
plet	(Specify only highest gr	rade completed)	. (Give kind of work done during life. DO NOT use retired)	most of workin	g			,
Completed	Elementary/Secondary (0-12)	College (1-4or 5+		tress			rest	auran	ı t
BeC	17. Father's Name (First, Middle, Las.	t)		18. /	Mother's Name	(First, Middle,	Maiden Su	ırname)	
임	John Pappas			Gwe	endolyr	Lore	na R	ond	
-	19a. Informant's Name/Relationship	(Type. Print)	19b. I	Mailing Address (Street and N					(ip Code)
	Frances Plumme	≥r/daught <i>e</i>		Endsleigh					
	20a. Method of Disposition			Disposition (Name of crematory or other place)		ate		tion - City or	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1 .	nke Crematory	1-10-	-2007	Belt	svill	e, MD
-	21. Signature of Funeral Service Lice			22. Name and Address of I	Facility 7	C	2001		<i>=</i>
		small mal	358	cremation + Fun	8 // 10 (A) 220	Dreen	MAC	ODr.	2128
	23a. Part1. Enter the disease, or con	nplications that caused t	the death. Do no						Approximate
	shock, or heart failure. List only Immediate Cause (Final			1					Interval Between Onset and Deat
	disease or condition resulting in death)		consequence of	brest can	nu				1 year
		Due to (of as a	consequence or)·					v
ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequence of):					
듩	Cause (Disease or injury								
Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
		- d						İ	
g,		- 4.							
edica								d. Date of deli	
n/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p					230	1. Date of dell	very
ician/Medica	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at t	☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			230	Month	very Day Year
hysician/Medical	23b. Was decedent pregnant	1 ☐Live birth 2	☐ Fetal death				230		,
Physicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal death ime of death	5 ☐ Other (specify)	Part I.	23e. Did to		Month	,
by Physicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal death ime of death	5 ☐ Other (specify)	⊃art I.	23e. Did to	obacco use	Month contribute to	Day Year
by Physicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal death ime of death	5 ☐ Other (specify)	Part I.	1 🗆 \	obacco use	Month contribute to	Day Year the cause of death
by Physicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal death ime of death	5 ☐ Other (specify)	Part I.	1 🗆 \ 24a. Was autop perfo	obacco use 'es 2 1	Month contribute to Mo 3 □ Pro 24b. Were aut prior to ceath?	the cause of death obably 4 Unknown topsy findings available completion of cause
Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown Part II. Other significant conditions	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal death ime of death	5 ☐ Other (specify)		1 _ \text{Yas} autop perfo	obacco use 'es 2 1 an sy rmed? 2 1 No	Month contribute to √o 3 □ Pro 24b. Were aut prior to c	the cause of death obably 4 Unknown topsy findings available completion of cause
Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	2 ∐Fetal death ime of death t not resulting in t	5 ☐ Other (specify)	Place of Death	1 \(\) 24a. Was autop perfo	obacco use /es 2] an sy rmed? 2] No	Month contribute to Mo 3 □ Pro 24b. Were aut prior to c death? 1 □ Yes	the cause of death obably 4 Unknotopsy findings available completion of cause
To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Hospital: 1 Inpatien 28a. Date of Injury	2 ☐ Fetal death ime of death the of death the not resulting in the the the the the the the the the the	be underlying cause given in factors and the underlying cause given in f	Place of Death ☐ Nursing Hom	24a. Was autor perfo 1 Yes (Check only o	obacco use /es 2 1 an an an ay rmed? 2 1 No ne) lence 6 [Month contribute to Mo 3 Pro 24b. Were aut prior to c death? 1 Yes	the cause of death obably 4 Unknotopsy findings available completion of cause
To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	2 ☐ Fetal death ime of death the of death the not resulting in the the the the the the the the the the	26. Injury at ury	Place of Death ☐ Nursing Hom	1 \(\) 24a. Was autop perfo	obacco use /es 2 1 an an an ay rmed? 2 1 No ne) lence 6 [Month contribute to Mo 3 Pro 24b. Were aut prior to c death? 1 Yes	the cause of death obably 4 Unknotopsy findings available completion of cause
To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	2 □ Fetal death ime of death the of death the the the the the the the the the the	be underlying cause given in factors and the underlying cause given in factors and the underlying cause given in factors are underlying cause give	Place of Death □ Nursing Hom 28 2 □ No	24a. Was autor period 1 Yes (Check only of the Sid. Describe h	obacco use /es 2 an / sy sy rmed? 2 DNo ne) lence 6 Enow injury o	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Spec	the cause of death obably 4 □Unknotopsy findings available of cause 2 □ 100 €
To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	t 2 ☐ ER/Outp t 2 ☐ ER/Outp (Year) 28b. Tir	26. Injury at ury	Place of Death □ Nursing Hom 28 2 □ No	24a. Was autor period 1 Yes (Check only of the Sid. Describe h	obacco use /es 2 1 an 2 sy rmed? 2 No ne) lence 6 cow injury o	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Spec	the cause of death obably 4 Unknotopsy findings available completion of cause
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	2 Fetal death ime of death ime of death ime of death ime of death it not resulting in to the control of the con	atient 3 DOA Other: 26. Injury at Work? M 28c. Injury at Work? M 1 Yes n, street, factory, office	Place of Death Nursing Hom 28 2 No	24a. Was autor performed in Yes (Check only of the Standard Control of the Sta	obacco use /es 2 an an ssy rmed? 2 DNo ne) lence 6 Downinjury of Street and N n, State)	Month contribute to Mo 3 Pro 24b. Were authorior to codeath? 1 Yes Other (Special Courred)	the cause of death obably 4 Unknown topsy findings available properties of cause 2 And of the cause of the ca
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injury (Month, Day) 28e. Place of injur building, etc. hysician: To the best of miner: On the basis of etc.	at 2 ER/Outp Tyear) If my knowledge, examination and/	be underlying cause given in factors and the underlying cause given in factors and the underlying cause given in factors are underlying cause give	Place of Death Nursing Hom 28 2 No 28 ate and place, a	24a. Was autor performed in Yes (Check only of the St. Location (St. City or Town and due to the	pobacco use /es 2 an an an an an an an an an an an an an a	Month contribute to No 3 □ Pro 24b. Were autor to content? 1 □ Yes Other (Special Content) Number or Ruind manner as	the cause of death obably 4 Unknown topsy findings available and the cause 2 140 cify)
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	Live birth 2	at 2 ER/Outp Tyear) If my knowledge, examination and/	be underlying cause given in factorial cause g	Place of Death Nursing Hom 28 2 No 28 ate and place, at	24a. Was autor performed to the control of the cont	obacco use /es 2	Month contribute to Mo 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Spec courred	the cause of death obably 4 Unknown topsy findings available of cause 2 Art of ca
To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injury (Month, Day) 28e. Place of injur building, etc. hysician: To the best of miner: On the basis of etc.	at 2 ER/Outp Tyear) If my knowledge, examination and/	be underlying cause given in factoring the underlying cause given in factoring the underlying cause given in factoring the underlying cause given in factoring the underlying cause given in factoring the underlying cause given in factoring the underlying th	Place of Death Nursing Hom 28 2 No 28 ate and place, and, death occurrent	24a. Was autor performed to the control of the cont	obacco use /es 2	Month contribute to Mo 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Spec occurred	the cause of death obably 4 Unknown topsy findings available of cause 2 Info
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	at 2 ER/Outp Tyear) 28b. Tir Inj Ty - At home, farm (Specify) Ty whowledge, examination and/ed.	26. Injury at Work? M 28c. Injury at Work? M 1 Yes death occurred at the time, da or investigation, in my opinior	Place of Death Nursing Hom 28 2 No 28 ate and place, and, death occurrent	24a. Was autor period of the control	obacco use /es 2 1 2 2 3 3 3 3 3 3 3 3	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Special Courred) Number or Rule and manner as lace, and due	the cause of death obably 4 □Unkn topsy findings avail tompletion of cause 2 □No cify) ral Route Number, stated. to the cause(s) n, Day, Year)
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	The standard of the standard o	atient 3 DOA Other: 4 atient 3 DOA Other: 4 me of Work? M 1 Yes n, street, factory, office death occurred at the time, da or investigation, in my opinior 29c. License num 3 Yes, Print)	Place of Death Nursing Hom 28 2 No 28 ate and place, and, death occurrent	24a. Was autor period of the control	obacco use /es 2 1 2 2 3 3 3 3 3 3 3 3	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Special Courred) Number or Rule and manner as lace, and due	the cause of death obably 4 Unknown topsy findings available topsy findings available topsy findings available topsy findings available topsy findings available topsy findings available topsy findings available topsy findings available topsy findings available topsy findings findings available topsy findings
Medical Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injury (Month, Day) 28e. Place of Injury (Month, Day) 28e. Place of Injury and building, etc. hysician: To the best of miner: On the basis of and manner state.	The stal death lime of death l	26. Injury at Work? M 28c. Injury at Work? M 1 Yes death occurred at the time, da or investigation, in my opinior	Place of Death Nursing Hom 28 2 No 28 ate and place, and, death occurrent	24a. Was autor period of the control	obacco use /es 2 1 2 2 3 3 3 3 3 3 3 3	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Special Courred) Number or Rule and manner as lace, and due	Day Year the cause of death babably 4 □Unkn topsy findings avail completion of cause 2 □ No sity) ral Route Number, stated. to the cause(s)
Certification: To Be Completed by Physicia	23b. Was decedent pregnant in the past 12 months? 1	1	The stal death lime of death l	atient 3 DOA Other: 4 atient 3 DOA Other: 4 me of Work? M 1 Yes n, street, factory, office death occurred at the time, da or investigation, in my opinior 29c. License num 3 Yes, Print)	Place of Death Nursing Hom 28 2 No 28 ate and place, and, death occurrent	24a. Was autor period of the control	obacco use /es 2 1 2 2 3 3 3 3 3 3 3 3	Month contribute to 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Special Courred) Number or Rule and manner as lace, and due	Day Year the cause of death obably 4 □Unkn topsy findings avail ompletion of cause 2 □ No sifty) ral Route Number, stated. to the cause(s) n, Day, Year) \$\int_{1} \int_{2} \int_{1} \int_{2} \int_{1} \int_{2} \int_{1} \int_{2} \int_{1} \int_{2} \int_{1} \int_{2} \int_{2} \int_{1} \int_{2} \int_{2} \int_{1} \int_{2} \int

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 1	tate of Ma per dr.(uyland / Depa 363,01710	artment of H	lealth and N Death	Mental Hyg	giene nag. NO 0	7 00371	
			Decedent's Name (First, Middle, Last)	illiam	Nelson	Schindhe	lm	2. Date of Dea	ıth	3. Time of Death	
	Physicia /Medic		William Nel	5001 5	Schilled	holm		Jan	Day 2	007 B:21 AM	
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death		4c. County	of Death	
			Howard County Gener	al Hosp	ital	Colum	nbia		Howard		
	Funeral		5. Social Security Number 6. Sex	2 ☐ F 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)	
	Director		219-42-0091 TMM		64 Yrs.			Oct 12,	1942	MD	
	and and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mary	ğ	MD Howard			Sykesvi1	16			1 □ Yes 21 No	
	288	rec	10e. Street and Number			10f. Zip Code		1	10g. Citîzen of W	/hat Country?	
	3a o	Funeral Director	1460 Coventry Meado	WS		2178	4		USA		
	death	ner	11. Marital Status 12.	Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-		e - American Indian, k. White, etc.	
စ္	or Its	F	1 Never Married 2 Married	1X Yes 2 N If Yes, Give	lo	1 ⊡ Yes 2 🛣 No	Specify:	riican, etc.;	Specify		
8	be filed within 72 hours after death with the Maryland stal Hygiene. id other than "natural", or Itams 23a or 28a-f show event, the Medical Evanji, ar must be redified at	d by	3 Widowed 4 Divorced	Year or Dates:	1908						
5-	"natu	Completed	15. Decedent's Educati (Specify only highest grade co	on <i>mpl</i> eted)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Industry	
12	withir and the supplemental sup	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		"		Social	Security	
d 2	filed Hygid thar int,		17. Father's Name (First, Middle, Last)		I'I	anager	18. Mother's Nam	e (First, Middle,			
Maryland 21215-0036	ed ita	To Be	Daniel Lester	Schindh	elm		Elizabe	th Loret	ta Edwa	rde	
<u></u>	shoul nd M marl		19a. Informant's Name/Relationship (Type,	Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Code)	
	and 2 saith a n 27 is		Mrs. Patricia Schind	helm (S _j	pouse) 146	O Coventr	y Meadow	s Dr., S	ykesvil	le, MD 21784	
ē,	~ 1 9 5		20a. Method of Disposition		20b. Place of Dispo			Date		City or Town, State	
Ê	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 14 ☐ Donation 5 ☐ Other (Specify)	oval from State		n Mem. Ga		5/2007	Marrio	ttsville, MD	
Baltimore,	그 문학생		21. Signature of Funeral Service Licensee	/ .						(Box 195)	
ä	Depariming Department of the series of the s		> Slean R. 9	Houges	Z S	ykesville	, MD 2178	34 (410)	-795-14((Box 195)	
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused	the death. Do not ent					Approximate Interval Between	
	Pnysician :	8 (1)	Immediate Cause (Final disease or condition	Hen		cople	lapaf	40		Onset and Death	
	/Medical		resulting in death)	Due to (or s	a consequence of):	ncepha	o opoc	7			
	Examiner		Sequentially list conditions, b.	civ	nos05						
	sit s	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	з вопецичнее об):						
	and and I-tran	хаш	that initiated events c resulting in death) Last	Due to (or as	a consequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	aiE			,						
687	icate phys s the	dicai	d								
×	leath certific attending p i for use as	/We	IF FEMALE: 23c. Was decedent pregnant	If yes, outcome					23d. Date	e of delivery	
Вох	death atter	Physician/Me	in the past 12 months?	1□Live birth 4□Pregnant at]Ectopic pregnancy] Other (s <i>pecify)</i>			Mor		
P.O.	that the dead by the detached	hysi	9 Unknown	9□ Unknown							
	res that igned b		Part II. Other significant conditions contrib	uting to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?	
ğ	quire an sig	ed It	liver can	er	· · · · · · · · · · · · · · · · · · ·			1 🗆 Y	es 2 No	3 ☐ Probably 4 ☑ Unknown	
S	aw requisible been 2 should	piet						24a. Was a	an 24b. V	Vere autopsy findings available irior to completion of cause of	
of Vital Records,	The lav	Completed by						perfor	med2 d	leath?	
ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	ne)		
) \	S 20 0	2	1 ☐ Yes 2 ☑ No	1 Minpatie			4 Nuising H	ome 5 Resid	ence 6 □Othe	ar (Specify)	
	ing P	on:	i delitatara:	28a. Date of Injur (Month, Day	y Year) 28b. Time o	Worl	k?	28d. Describe h	ow injury occurre	9d	
Sio	tandi leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	006 Lanatina (C	Marie and a second field of the second field o	and an Private Plants Alicenter	
Division	or At or At Direction by	Certification:	4 Homicide determined	building, etc	ry - At home, farm, st c. (Specify)	eet, factory, office		City or Tow		er or Rural Route Number,	
_	pital ours s aral l		29a. Certifier 1 Certifying Physici	an: To the hest of	of my knowledge, deat	h occurred at the tin	ne, date and place	and due to the o	Pause(s) and mar	nner as stated	
	24 hc 24 hc Fun etely	Medical	(Check only 2 Madical Examinar		examination and/or in						
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	C 1		29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)	
			> Kunden Hay	100)	M.D.	D006	2108		Jan	1. 2007	
1			30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Type,	Print)				.,	
	ψ		Dr. Kweku Hayford, N	1.D. HC	GH, 5755 C	edar Lane	. Columb	ia. MD 2	21044		
0	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	9	,				
	Registi	ar	JAN 1 0 2007 A	1 1	and the same of th						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Day 3 1. Decedent's Name (First, Middle, Last) -Month **Physician** Jannan 2007 EDWARD THOMAS, JR. /Medical 4c. County of Death 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ARUNDEL ANNE BALTO. WASHINGTON MED. CENTER GLEN BURNIE If Under 1 Year | If Und 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs. MASSACHUSETTS Director 90 21, 1916 10 9421 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Directo MARYLAND ANNE ARUNDEL MILLERSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- " any Injury or other transmitted." 24 ROLL-PARK VILLAGE 21108 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛛 No Specify: Specify: \$ 3 X Widowed 4 ☐ Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHIPFITTER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ EDWARD R. THOMAS, SR. ANNA LENTZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DENNY THOMAS / SON 7743 MEADOW RD. PASADENA, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 3 □ Other (Specify) GLEN HAVEN MEM. PARK JAN. 8,2007 GLEN BURNIE, MD re of Funeral Service Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21. Signat 421 CRAIN HWY. SE GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Corohan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1□ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 □ DOA Certification: To this the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 TYes 2 No M death. Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending hin 24 hours a completely within 2 2

with the Maryland

Maryland 21215-0036

EDWARD

State Registrar

b

DHMH 17 Rev 1/2001

Year) JAN 1 0 2007

29b. Signature and title of certifier

30. Name and addre

31. Date filed (Month, Day,

s f person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Richie Treadway 200 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** mare day If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (101/24/1951 Birthplace (State or Foreign
 Country) **Funeral** 213-52-5870 Min Days LEM 2 F Yrs. Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "netural", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at MD Baltimore Middle River 1 □ Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 B Oak Grove Drive 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry .
Telecommunication al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Person 17. Father's Name (First, Middle, Last)
Hurl Treadway 18. Mother's Name (First, Middle, Maiden Sumame)
Florence Linkous Be Pages 1 and 2 should 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3524 Bay Drive Middle River, MD 21220 and 19a. Informant's Name/Relationship (Type, Print) Angela Woolery/StepDaughter permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie eny injury or other treu 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 9 an 10 Chesapeake Crematory Inc. 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Crematide and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part.I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 Yes 2 No 1 ☐ Yes 2 No : After this certifical funeral director, r Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) D64408

Registrar

DHMH 17 Rev 1/2001

Franklin

32. Registrar's Signature

ware brive Ba

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Tay Behar

31. Date filed (Month, Day, Year)

Physician /Medical Examiner **Funeral** Director death with the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Funeral þ Completed 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Be Injury or other permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and

Division or Vital Records, P.O. Box 68760

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 30 pM Rajamani Voraganty 2007 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham Doctors Community If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 28, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ▼M 2 □ F 69 216-96-5373 India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1√Yes 2□No Prince Georges MD Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7618 Seans Terrace 20706 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Asian Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ranganathan Voraganti Lakshmi Panthalu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ravi Voraganty, Son 37155 Lord Baltimore Ln, Ocean View, DE 19970 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 1/6/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Svs. 21. Signature of Foneral Service Licensee 933 Gist Avenue Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN HEMORRHAGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL TRANSPLANT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Completed IMMUNOS UPPRESSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 1 Impatient ို 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural thin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 30. Name and address of person who Impleted cause of death (Item 23a) (Type, Print) N KEVIN EKFAN 8118 GOOD LUC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 1:10 A M January Carl Edwin Wolfe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Owings Mills 9773 Groffs Mill Dr. Apt.316 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 21,1938 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** XXM 2 F Maryland 68 Director 212-36-3132 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes X X No Owings Mills Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21117 9773 Groffs Mill Dr. Apt.316 Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 对 Yes 2 No 1955— If Yes, Give Year or Dates: 1958 filed within 72 hours after 1 ☐ Never Married 🏋 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🔀 🛣 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sweet Heart Cup Maintenance Mechanic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othrany frijury or other traumatic event. Be Charles Hicks Wolfe Manza Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Apt. 316
9773 Groffs Mill Dr. Owings Mills, MD 21117 19a. Informant's Name/Relationship (Type. Print) Wife Beatrice Kathrine Wolfe, <u>9773 Groffs Mill</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1/16/07 Owings Mills, MD Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Renal 1.11505554 /Medical Examiner Benel Failvir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the burial Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Diebetes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Voscular Discuse autopsy performed? Yes 2☑No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ို 1 ☐ Yes 2 ☐ No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h. Time of 28c. Injury at Work? After 1 Certification: Injury 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H 53088 Janvary 8,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #135 Baltimore Maryland 6014 00 1838 Greene Road Tree 32. Registrar's Signature State State of the state of Registrar

			1 - For State Registrar		State of M	/larylar		artment rtificate			and M	lental Hy	giene Reg. No.	007	00377
gi.	Physici		Decedent's Name (First, JOHN	Middle, Last)		WEIS	s			-		2. Date of De	aath RY ^{Day}	20 0 7	3. Time of Death 12:40 am
	/Medio Examir		4a. Facility Name (If not ins	-					Town, or	Location o	of Death			County of Death	
	Funeral Director		5. Social Security Number 212 12 12 123		7. /]M 2□ F	Age (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, D. 2/29/	1 9 2 4	9. Birth Cou MARY	place (State or Foreign INTY) LAND
	Maryland a-f ehow	tor		ent County LTIMO	RE	10c. Ci	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28a	al Director	10e. Street and Number 1503 WEYB	URN R	OAD			10f. Zip		2123	7		10g. Citiz	en of What Cou US	
020	i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. I fem 27 is marked other than "naturel; or items 23a or 28a-f ehow other traumatic event, the MacLeal Expandrer must be notified and	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Directors	Married	12. Was Deceder Armed Force 1 Types 2 [If Yes, Give Year or Date:	s?] No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: WHI	, etc.
0-6171	within 72 ho ene. than "natur tra Mucical	Completed		cedent's Educ highest grade		or 5+)	(Give	dent's Usua kind of wor DO NOT us ECTR	rk done d se retired	<i>luri</i> ng mos)		ing		od of Business/li	
אומנות ל	should be filed with and Mental Hygiene a marked other tha umatic event, treat	To Be Co	17. Father's Name (First, M								r's Name	(First, Middle		Sumame)	
_	d 2 a 7 ls		19a. Informant's Name/Re PEGGY LANG	LEY/S			806	3 ROS	SLYN		В	ALTIMO	ORE,	Town, State, Zi	237
Danillior	Pages nent o ant: If ary or		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 O	ation 3 □R her (Specify)		te		matory or o	ther place ${ m TOR}$.	Y	1/10	0/07	BAL	TIMORE	C, MD
B D	permit. Departr Importe ony inje		23a. Part1. Enter the disershock, or heart failure	5		sed the dea						CH / RO BALT or respiratory a		E, MD	Z1237 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		ADV		ALZE								Onset and Death 6 YRS.
	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a Due t		. ,								
<u> </u>	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregninthe past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ant	3c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	2 Feta	at death 3	□Ectopic pr □ Other (sp					2	3d. Date of deliv	very Day Year
cords, r.	w requires that the de been signed by the a should be detached	þ	Part II. Other significant c	onditions con	ntributing to death	n but not res	sulting in the u	inderlying c	ause give	en in Part I				se contribute to	the cause of death?
nec nec	The lay ate has page 2	Completed										24a. Was auto perf		24b. Were aut prior to c death?	opsy findings available ompletion of cause of 2∰ No
N I I I	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to r examiner?		fospital:				Oth		of Death	(Check only	one)		
5	Phys this al dir	ů.	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 🔲 Inpa		ER/Outpatie			4]K] NU		me 5 Res 28d. Describe		Other (Spec	ity)
DIVISION	ttending death. stor: After / the funer	Certification:	1 ☑ Natural 5 ☐ 2 ☐ Accident 3 ☐ Suicide 6 ☐	Pending investigation Could not be	28a. Date of li (Month, i		Injury	М		Yes 2 🗆	No				ral Route Number,
2	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,		4 _ nomelde	determined ertifying Phys	building,	etc. (Speci	fy)			ne, date ar		City or To	wn, State)		
	To the Hos within 24 h To the Fur completely	edical			ner: On the basis and manner	s of examin									
	To the virthing Comp	Me	29b. Signature and title of	certifier)		M.D.		D17	number			29d. Date	ary 9,	
	Mx,		30. Name and address of p					Print)		-	E				and 2123

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ODIGINIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

A 11 Diff. per H. Chr. 2/1/0/ WS

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Day **Physician** 01 04 2007 09:15am David Samuel Whitacre /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6920 Prince Georges Ave Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 766 - 223 24 2766 6. Sex 7. Age (In yrs. last birthday) 51 8. Date of Birth (Month, Day, Year) 10-05-1955 Birthplace (State or Foreign Country) **Funeral** Days Hours 11XIM 2□ F Yrs. Germany Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits work rthan "natural", or items 23a or 28a-f ahov the Madical Examiner must be notified at 1 XYes 2 No Directo MD Montgomery Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20912 6920 Prince Georges Ave USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 21X No If Yes, Give Year or Dates: 1⊠ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Attorney Prince George County other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of Donald Whitacre Josephine Spindle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannine Anderson/friend 6915 Prince Georges Ave Takoma Park MD 20912 Health it 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of h 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State ö Depertment of important: If any injury or once. Chesapeake Crematory 1-9-2007 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licenses 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer years **Physician** eritoneal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attanding Physician: : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours eft To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45880

State Registrar C. Hwang, M.D. 1396
31. Date filed (Morith, Day, Year)

JAN 1 0

14

death

filed within 72 hours after

Maryland 21215-0036

altimore,

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Space !

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. Hwana, M.D. 1396 Riccard Dr. Rockville, MD 20850

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Richard Anders Zorn January 4 2007 04:02 "/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) March 9,1931 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**∑**M 2□ F Months Hours Min. 75 Director 218-28-3264 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Mary1and Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1242 Chateau Green Ct. 21015 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐ Yes 2 🔀 If Yes, Give Year or Dates: 2 **X**No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No Specify. ģ 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) lith and Mental Hygiene. 27 is marked other than " r traumatic event, the Med Consulting Elementary/Secondary (0-12) College (1-4or 5+) <u>12th Grade</u> Engineers Surveyor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gunnar Zorn Eva Sundvau ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr 27 Barbara Zorn (Wife) 1242 Chateau Green Ct, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2007 Timonium, Maryland 21. Signature of Europa Sarula Line 22. Name and Address of Facility Schimunek Funeral Home of Bel Air all Inc. 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 110 /Medical Due to (ar as a consequence a) **Examiner** re 113 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown certificate has been si rector, page 2 should l Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death. Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. the Funeral Directory filled in by 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 mo

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Registrar

30. Name and address

32 Registrar's Signature

ion

rson who completed cause of death (Item 23a) (Type, Print)

0 6/

ORIGINAL

JOSTG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death January 6, 2007 0025 A. M **Physician** Abraham Moses /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For Months | Days | Hours | Min. | Mar. | 27, | 913 | Rhode Island 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 11☑M 2□F 93 Director 037-16-6233 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County ul Hygiene. other than "natural", or Iteme 23a or 28a-f ehow vent, the Medical Exertiteer must be motified at 1 XYes 2 No MD Harford Aberdeen Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 45 Smith Avenue 21001 U.S.A. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: Specify White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy important: If Item 27 is marked oth eny jury or other traumatic event once. Charles Baker Sarah Rachel Liebovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise Gordon (P/R Executor) 229 Farm Road Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1/8/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hebrew Friendship Cem. Baltimore, MD 22 Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen,, Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -a.lure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): MUR Due to (or as a consequence of): of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? APPEADO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 PNo 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA r 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certain D0062903 01/06/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAS ATRASH, MO 319 S Union AVE H De Gace MD 21078 410 - 939-4477 ANAS ATRASHIMO Harre 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JAN 1 0

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No. 2007	038
Physicia Medical Exami	2111/	Month Day Year Loope L	
Todical Exam		Daniel Edwin Bikle January 3, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		Washington County Hospital Hagerstown Washington	
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min	
Director	-	212-50-8989 12 M 2 F 58 Yrs. April 3 1948 Country Mar	yland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside	City Limits
*	_	Maryland Washington Hagerstown	2 XNo
daryland 28a-f show 1 at once.	· ·	10e Street and Number 10f. Zip Code 10g. Citizen of What Country?	
th the Maryland 23a or 28a-f sho		14130 Pennsylvania Ave Apt 23 21742 U.S.A.	
tems 2	neral	Never married 2 Y married 2 Y married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lack,
ter death ", or ite	, Fun	1 Yes 2 No 3 Wildowed 4 Diversed III Yes Give Year	
ours af atural	d b	for Deads and Schooling (Specific all highers and a smooth of). I do Deads of the light for the first	
n 72 h	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
5-0036 led within 72 Hygiene other than the Medical	E O	12 Sales Automotive 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)	
215-0036 be filed within 7 ntal Hygiene rked other thau ent, the Medica	Be C		
21215-0036 hould be filed within 72 hours a nd Mental Hygiene is marked other than "natura" tite event, the Medical Examin	ည		
ME and 2 s and 2 s and 3 s and		Edith M. Bikle / Wife P.O. Box 264 Hagerstown Maryland 21742-2064 20a Method of Disposition 20b Place of Disposition (Name of cemetery) Date 120c Location - City or Town State	
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State	
Baltimore, permit Pages I an Department of Hea Important: If ite injury or other tr.		4 Donation 5 Other Specify: Rest Haven Cemetery 1/08/2007 Hagerstown, Mary 21 Apprenture of Fungal Service Licensee 122 Name and Address of Facility Post Haven Fungal Change	land_
Balt permit Depart Import injury		21 Agenature of Fune all Service Licensee 22 Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland	21742
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima	ite Interval
/Medical xaminer		Immediate Cause (Final disease a. Hypertensive cardiovascular disease	ath
4		b	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause	
	Examiner	(ursease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	
760, reate be executed thysician and the burial - transit			
O, e be ex sician burial	/Medical	X UNPENDED	
8760, tificate be ng physic as the bur			Year
Box 687; death certificate at the attending	Physician	Pregnant at time of death 5 Other (Specify))
O. B. trthe de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of	death?
res that the d signed by the	d by	1 Yes 2 No 3 Probably 4 V	Jnknown
ords, w requir	lete	24a. Was an 24b. Were autopsy finding: autopsy prior to completion of	
Reco The law icate has	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 □	No
tal Rectian: The certificate	Be C	25. Was case referred to medical 26. Place of Death (Check only one)	
F Vit Physic or this or	To E	1 Ves 2 No ER/Outpatient 3 DOA Start Nursing Home 5 Residence 6 Other Scene	
Division of Vital Records, tal or Attending Physician: The law requing after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	ion:	27. Manner of Death 28a Date of Injury (Month, Day,Year) 28b Time of Injury 22c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred	
risior r Attencer death	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number Numbe	mber, City
Divis pital or At ours after d eral Direc	Certification:	3 Suicide 6 Could not be determined (Specify) (Specify)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		1 29a Certiller 1 2 B	
To with	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year	r)
X		Mura Stassell MD O.C.M.E. January 4, 2007	
1/1/6		30. Name and address of person who completed cause of death (Item 23a)	
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
S Regis	tate trar		

	1 - For State Registrar	State of Maryla			of Health ar of Death		Re	g. No.	7	00382
Physician	Decedent's Name (First, Middle,					2	. Date of Death Month		'ear	3. Time of Death
/Medical	Margaret Lou						JANUAR	1 20	07	1:43 p ^M
Examiner	4a. Facility Name (If not institution, o				wn, or Location of I			4c. County of		
	St. Mary's F	lospital Sex 7. Age (In yrs	last highday)	Le	onardtow		Date of Righ	St. I		
Funeral Director	220-62-7128	1 □ M 2 XF 7. Age (111 y/s				Min.	Date of Birth (Month, Day, OV. 12,	Year)		ce (State or Foreign
110001	Usual Residence of Decedent					1/4	00. 12,	1933 1	Maryl	Land
Importent: if item 27 is marked other then "naturel", or itema 23a or 28a-1 show eny Injury or other treumatic event, the Madical Examinar must be notified at once. To Be Completed by Funeral Director	10a. State 10b. County		ity, Town or Lo	cation					100	d. Inside City Limits
cto	Maryland St. Ma	ary's		Aven	ue					1 □ Yes 2 🔀 No
te nutifie Director	10e. Street and Number			10f. Zip Co			10	g. Citizen of Wh		y ?
rai	20910 Olin Matt		10 10	206		0.10		USA		
Sample meat	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No	J.S. 13. V	Vas Deceden f Yes, specify	it of Hispanic Origin Cuban, Mexican, f	Puerto Ri	ty Yes or No- can, etc.)	14. Race - Black,	White, et	
Ď.	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2K	No Specity:			Specify:	W	Thite
t. the Medical E	15. Decedent's	Education	16a. Deced	ient's Usual C	Occupation	4 4 . !	1	6b. Kind of Busi	ness/indu	istry
Med n	(Specify only highest : Elementary/Secondary (0-12) 1 2	College (1-4or 5+)			done during most o retired)	working				
CO L	12		C	ashier				Grocery		e
Be e	17. Father's Name (First, Middle, La							laiden Sumame)		
of To								anore Ha		
5	19a. Informant's Name/Relationship Joseph L. Bryant		1		treet and Number			-	ate, Zip C	Code)
th.	20a. Method of Disposition		Place of Dispo			Dat	-	Oc. Location - C	ity or Tow	n State
o o o	1 XBurial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or othe	orplace) Ja	nuary	75,	Bushwood		
5	4 ☐ Donation 5 ☐ Other (Spe 21. Signature 1 Funeral Service Lice	V 1	red Heart			200			, Mary	/Tanu
eny l	March 18	EHOLD O	Ma	ttingle	Address of Facility y-Gardiner 270, Leonar	Funer	al Home,	P.A.		
	23a. Part1. Enter the disease, or co	omplications that caused the dee							P	Approximate
icían	Immediate Cause (Final	a. Metay								nterval Between Onset and Death
dical	disease or condition resulting in death)	Due to (or as a conse			www	Co	me	_		3 Months
niner	Sequentially list conditions	b								
je i	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence or):							
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
<u> </u>		Due to (or as a conse	quence of):							
the burial-transit		d		 -						
Physician/Medic	IF FEMALE:	23c. If yes, outcome of pregn	ancv					22d Date	of dalama	
foru	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pregr Other (specif				23d. Date Month		ay Year
oy me or me	1 ☐ Yes 2 2 2 No 9 ☐ Unknown	9□ Unknown			,,					
be det	Part II. Other significant condition	s contributing to death but not re	sulting in the ur	nderlying caus	se given in Part I.		23e. Did tob	acco use contrib	ute to the	cause of death?
should b						-	1 🗌 Ye:	2 2 00 3	Probab	bly 4 □Unknown
page 2 should							24a. Was an		re autops	sy findings available
pege 2 :							autopsy perform 1 Yes 2	ed? dea	or to comp ath?] Yes 2	pletion of cause of
ं ७	25. Was case referred to medical				26. Place of	Death (Check only one		, 103 2,	200
2 G	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2.	ER/Outpatien	t 3□ DOA	Other: 4 Nursi	ng Home	5 Resider	ice 6 Other	(Specify)	
		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28	d. Describe how	v injury occurred		
	2 Accident investigat			М	1 Yes 2 No					
rii i	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ed 28e. Place of Injury - At I	nome, farm, stre ify)	eet, factory, of	ffice	28	f. Location (Str. City or Town,	et and Number State)	or Rura l F	Route Number,
Sel			Supplied to you trail		and the same of th	weet to the last	a (a o o o o o o o o o o	TO APPEND TO A PARTY IN	2 200 200 200	
pletely fill	29a Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kn raminer: On the basis of examin and manner stated.	uwledge, death ation and/or inv	estigation, in	my opinion, death	occurred	at the time, da	ito(s) and main te and place, an	er as clat d due to ti	he cause(s)
completely filled in by the Medical Certific	29b. Signature and title of certifier	and manner stated.		29c. Li	icense number		29	d. Date signed (Month, Da	av, Year)
8	> 5c 6	10 M.	D.	7	D5431	+6		1/2/0		,. · · ==·/
	30. Name and address of person wh	no completed cause of death (to	m 23a) /Time	Print)		•	D-mar-	1 1		
well-energy	CHANDRA SAJJA	SHAH ASSOC HOL			20636					
State	31. Date filed (Month, Day, Year)	3. Registrar's Sign		ع سد	-0000					
Registrar	JAN 0 2	2007 Beren 1	7. Ass	النامة						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 1:30 P.M January 4, 2007 Paul Edward Burns Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Avalon Manor Health Care Center Washington Hagerstown 8. Date of Birth (Month, Day, Year) OCt. 18, 1919 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1⊠M 2□F Months Days 87 Yrs. Maryland 204-03-3978 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Hagerstown Md. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A12011 Sherwood Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 41-46 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Brick Mason 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary C. Kline Charles C. Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11806 Allegheny Ct. Smithsburg, Md. 21783 <u>Paul E. Burns Jr. (Son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2007 Smithsburg, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 101414 JW15 201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Due to (or as a consequence of): Hypoalbumine mia Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown

Physician /Medical **Examiner**

burial-transit

igned by the attending physician be detached for use as the buria

page 2 certificate

the funeral director,

completely filled in by

After

or Attending

To the Hospital within 24 hours a

death.

after death Director:

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funerai

δ

Completed

Be

2

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

Funeral

Director

r than "natural", or itams 23s or 28s-f show the Medical Exercitivat for notified at

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once</u>.

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2.☑No 1 ☐ Yes 26. Place of Death (Check only one)

25. Was case referre examiner?	
27. Manner of Death	
1 Natural	5 Pendin

5 Pending

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

2 Accident

3 Suicide

4 Thomicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number DO60396

HA6

29d. Date signed (Month, Day, Year) 105

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muc THRID 200 D 31. Date filed (Month, Day, Year)

State Registrar

JAN 0 9 2007 37 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:56/tm 2, 2007 4c. County of Death Shirley Adele Brown Danvar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown r 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 15,1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Months Days Hours 79 Yrs. Director 178-22-8304 District of Columbia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director PA Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
It I flem 27 is marked other than "natural", or Items 23a or 1 in yor other traumatic event, the Medical Examiner must be not yor other traumatic event, the Medical Examiner must be no 1456 Pleasant Grove Road 17267 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Distribution Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Frank E. Sharpless Della Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie F. Wesley/Daughter 11525 Scottsbury Terrace Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If Its any Injury or o once. 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/05/07 Pleasant Grove Cemetery Warfordsburg, PA 21 Sanature of Funeral Sende 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 2 No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 225 5 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Oak Hill Hhmed 12821 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 117 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Carder Robert 03-2007 6:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Oldtown 17905 E Wilson Road, SE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days **№** M 2□ F Hours Feb 20 83 577-38-9919 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or iteme 23a or 28a-f show other traumatic event, the Medical Examinational be notified at Oldtown MD Allegany 1 Yes X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 17905 E. Wilson Road, SE 21555 12. Was Decedent Ever in U.S. Armed Forces? 1√1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No MYes, Give Year or Dates: WW II Specify: Specify white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mantal Hygiene important: if item 27 is marked other than any injury or other traumatic event, ILAA ODG. U.S. Navy Lt. Commander 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ivy Elsie Carder Noah Sanders Carder 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17905 E. Wilson Road, Oldtown MD 21555 19a. Informant's Name/Relationship (Type, Print) **Doris Carder** wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Oldtown Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/6/2007 MD Oldtown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Na Scarbelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Prostate Carcinom · Metastatic 9-27-1991 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Tes 2 No Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23371 1-3-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Qamar Zaman M.D. 31. Date filed (Month Park) 2007

ORIGINAL

Ment Avenue Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 00386 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thomas Edward Franks, Sr. 7:50A January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 107 Church Lane Barclay Queen Anne 6. Sex 1 Å M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 54 Director 214-54-7946 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel, or Itema 23a or 28a-f show any Injury or other traumatic avent, the Medical Examinating the notified at once. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Queen Anne Barclay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Church Lane 21607 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Long Haul 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Franks Helen Kilroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste R. Franks wife PO Box 24 Barclay, Maryland 21607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Greensboro Cemetery 01/03/2007 4 □ Donation 5 □ Other (Specify) Greensboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral PO Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached in 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Defobably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 hes autopsy performe certificate 1 ☐ Yes 2 No ours efter death. neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Aesidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 296. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) PNNST: CENTENVILLE 5'h ANDINAV ATRICIC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State (DONE) 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental	Hygie Reg.	C 0 0 1	00387				
			Decedent's Neme (First, Middle, Last)		of Death		3. Time of Death				
1	Physicia		Olive Marie Feyl	Janu		1, 2007	7:30 A M				
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Dea						
	Examin	er	Caroline Nursing Home Denton			Carolin	e				
-	-		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	s. 8. Date	of Birth th, Day, Ye	9. Bir	thplace (State or Foreign				
п	Funeral Director		221-12-0611 1 M 2X F 83 Yrs. Months Days Hours Min	6/1	16/192	$\begin{array}{c c} \mathbf{par} \\ 23 & \mathbf{De1} \end{array}$	aware				
			Usuel Residence of Decedent								
	ylanc Mow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
	Mar	ō	MD Caroline Greensboro				1 □Yes 2X No				
	r 28g	rec	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What Co	ountry?				
	3a o		12619 Greensboro Road 21639			U.S.A.					
	ms 2	Jer	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes	or No-	14. Race - Ame					
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or Items 23a or 28a-f ahow avent, the Modral Examiner most be notified at	by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puel Never Married 2 Married 1 Yes 2 No	no Alcan, e	ic.)	Black, White					
ş	tura stura	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		161	b. Kind of Business	/Industry				
 2	filed within 72 Hygiene. other then "natem".	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	orking							
12	with iene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker		(own home					
0	filed within Hygiene. other than	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, I	Middle, Mai	iden Sumame)					
an	ld be ental ked o	To B	Arley M. Tingle Mary	L. I	Legate	es					
2	2 should be and Mental Is marked o	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Rural Route	Number, C	ity or Town, State, .	Zip Code)				
S	d 2 sith ar		Barbara A. Spicher/ daughter 12619 Greensboro, Road	d; Gre	ensb	oro, MD 2	1639				
Ġ,	1 an Heal tem 2	. 3	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	200	c. Location - City or	Town, State				
altimore,	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Chesapeake Cremat Ctr 1/0	3/2007	7 C1	nester, M	D				
	nt. Purture	1									
Ba	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a QDE8.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenl PO Box 160; Greens	bein I boro,	Tunera MD 2	al Home, 1639	PA				
Н	4 +		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respira	tory arrest	,	Approximate Interval Between				
Ц,	Physician		Immediate Cause (Final disease or condition Alaheimer's Dement			Onset and Death					
	/Medical		resulting in death) Due to (or as a consequence of):	1 6 04			-Jeans				
4	Examiner										
N. S		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.								
,	exec n an ial-tr	Exa	resulting in death) Last Due to (or as a consequence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	d d								
89	ficat phy s the	edi									
	eath certific attending p	M/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery				
Вох	atter for u	by Physician/M	in the past 12 months? 4 Prepare at least 5 Determine from the past 12 months?			Month	Day Year				
o.	that the de ed by the detached	ysi	1 Yes 2 No 9 Unknown 9 Unknown								
۵.	that the od by detac	4	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236	. Did tobac	cco use contribute to	the cause of death?				
ds,	ires tha signed d be del				1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown				
Ö	w requir been si should	Completed		24.	106	0.0	Carina a malabla				
ec	has b	ldu		248	 Was an autopsy performer 	prior to	utopsy findings available completion of cause of				
=	The cate	S		10		No 1 ☐ Yes	2 No				
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	eath (Check	only one)						
7	Physician: r this certifica ral director, p	2				e 6 Other (Spe	cify)				
n c	ding P. h. After t	.uo	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Des	scribe how	injury occurred					
0	death.	ati	2 Accident investigation M 1 Yes 2 No								
Division of Vital Records,	l or Attank after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Stree or Town, S		ural Route Number,				
	itelo rsaf ral D	Ce									
	To the Hospitel or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Chack only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Chack only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date oc								
	thin the other	Me	29b. Signature and title of certifier 29c. License number		29d	. Date signed (Mon	th, Day, Year)				
)	To To cor		> =7 AH MO DO04753) i		1/2/0	7				
				s by	1	, 2,0	1				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
			Wafik Zaki, MD 920 Market Street; Denton, MD 21629 31. Date filed (Month. Day, Year) 22. Registrar's Signature								
	Sta Regista		JAN 0 4 2307								
1	riegist	4-1	A CONTRACTOR OF THE PROPERTY O								

DHMH 17 Rev 1/2001

ORIGINAL

07-00041 John Frizzell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

John Trizzen	1- For State Criticate of Registrar	, ,	Reg. No. 201	7 0038
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) John Lee Frizzell		Date of Death Month Day Year January 2, 2007	3 Time of Death 1026 hrs
-	4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death	4c. County of De	
Funeral	64 East Broadway 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bel Air If Under 1 Year If Under 24Hrs. 8	Harford B. Date of Birth(MM/DD/YYYY) 9	Birthplace (State or
Director	212-76-2656 1x M 2 F 49 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Aug. 19, 1957	Country DC
* any	10a. State 10b. County 10c. City, Town or Location	٦		10d. Inside City Limits
Maryland 28a-f show at at once. ector	Maryland Harford Bel Ai	r 10f. Zip Code	10g. Citizen of What C	1 Yes 2 X
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	64 East Broadway	21014	USA	
a, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "matural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ric		
natural" xamine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	'es 2 No specify: Usual Occupation (Give kind of work t of working life DO NOT use retired'	done 16b Kind of Busine	
5-0036 ed within 72 hour lygiene other than "naturitie Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	e Clerk		cery Clerk
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Oris Elmer Frizzell	'	rst, Middle, Maiden Surname) Ssie Eunice Boid	ce
MD 21 d 2 should lth and Me n 27 is ma anmatic ev		Address (Street and Number or Rura Parkvale Road, Ro		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner To Be Completed by 1	20a Method of Disposition 1 Burial 2 **Cremation 3 Removal from State Metropoli	r placo)	an. 8	, i
Baltir Permit P Departme Importan	4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee	me and Address of Facultins I	<u>2007 Alexandr:</u> Funeral Home Ind	ia, Virginia
Physician	23a Part I Enter the disease, or complications that caused the death. Do not enter the	University Blvd.	W. Silver Spi	
/Medical Examiner	făliure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Narcotic (morphine and ox Due to (or as a consequence of):	ycodone) intoxication	1	Between Onset and Death
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted Insit Examiner	Cause Enter Underlying Cause C (Disease or injury that initiated			
760, frate be executed sphysician and the burial - transit	d			
760, cate be execut physician and the burial - tra		ME, g863, 1/19/07 TT		
ox 68 ath certif attending or use as	1 Vos. 2 No. 9 University 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnancy (Specify)	23d Date of deliv	very Day Year
O. Bc at the dea 1 by the a tached for	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	23e Did tobacco use contribute	to the cause of death?
S, P.(uires that in signed id be deta ed by			1 Yes 2 No 3 F	
of Vital Records, ing Physician: The law require After this certificate has been signeral director, page 2 should bon: To Be Completed	<u> </u>			autopsy findings available to completion of cause of
1 of Vital Rec ling Physician: The I After this certificate b funeral director, page on: To Be Com	25. Was case referred to medical	26.Place of Death (Check only	1 🗸 Yes 2 No 1 🗸	Yes 2 No
f Vital Physician Prisician rat director To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	[Othor		her. Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach sartification: To Be Completed by P	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 You 2 - No	d. Describe how injury occurred	
Division c spiral or Attending hours after death neral Director: Aft (Affled in by the fun Certification	2 Accident Investigation 3 Suicide 6 X Could not be 2 Piace of Injury - At home, farm, street,	Jan	unknown f. Location (Street and Number or	Rural Route Number, City
Dispital ospital hours a meral 1 y filled	4 Homicide determined (Specify) Found in residence		orTown, State) 64 E. Br el Air, MD	
Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of my knowledge, death occurred and manner stated.	n, in my opinion, death occurred at th		
IT	29b. Signature and title of certifier Mina Parassell, MiD.	29c. License number O.C.M.E.	January 3, 200	
	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21	201	
State Registrar	31. Date filed (YAN Day Year) 2007 Registrar's Signature	و		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#24a, per VERB. G863, 711/0/ WS
State of Maryland / Department of Health and Mental Hygiene) 00389 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 3:55 AM **Physician** 4c. County of Death 2007 ROBERT L. GILES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 1 M 2 □ F Hours 70 Yrs. 204-28-3119 Director 9/4/1936 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mentel Hygiene. ?7 is marked other then "naturel", or items 23a or 28a-f show traumattc svent, tra Medical Examinat must be notified at 1 □Xes 2 □ No MD Harford Aberdeen Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21001 340 Mount Royal Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 TyPes 2 □ No If Yes, Give Year or Dates: Unknown 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>ک</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transit Trucking Truck Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sanford Giles Janie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: If Itsm 27 is any injury or other tra once. 971 Top View Drive, Edgewood, MD 21040 Tony Giles/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity AME Cemetery 1/5/2007 Delta, PA 21. Signulure of Funeral Service Lice 22. Name and Address of Facility MACO Harkins Funeral Home, Inc., Delta, PA 17314 M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immédiate Cause (Final Post Obstructive Preunoni **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner una Mass Usknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): NR#W&∞4 20765 Division of Vital Records, P.O. Box 68760, So Physician/Medical Examiner been signed by the attending physician end should be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 0515 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours effer death.

To the Funeral Director: Affer this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 ☐ No Giles, Robert 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 20 ans 00053568 Nanuary 1, 2007 30. Name and address of pers completed cause of death (Item 23a) (Type, Print) 31. Date tited (Month, Day, Year) MD 62. Registrar's Signature State JAN 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** ELITHA ELLEN GRANGER January 6 2007 11:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2**X** F 034-07-5530 94 Massachusetts Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Frederick Ijamsville 1 □Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2301 Persimmon Drive 21754 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Silas Granger Mary ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Granger, Son 2301 Persimmon Drive, Ijamsville Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 ☐Removal from State Smithsburg Crematory Jan 8, 2007, Smithsburg, Maryland 4 Donation 5 Other (Specify) LFuneral Service Linens Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 21. Signature, M00706 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Condia vonula **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-tran-Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 s certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Date of Injury (Month, Day Year) 1 Tyes 2 ER/Outpatient 3 DOA 2 this 27. Manner of Peatl 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural Accident 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) 6 Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- State of Maryland / Department of Health and Mental Hygiene ()
Registrar

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 **Physician** Alfred P. Harris 2007 0725 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Gumberland Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign) **Funeral** Months Jun 13, 1931 **X**□ M 2□ F Days Hours VVV (try) 75 Yrs. 218-24-8313 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or Items 23s or 28s-4 show traumatic event. Its Modical Exemitment on Its notified at Frostburg MD Allegany 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21532 107 Maple Terrace Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0036 Specify: Specify.white δ 3 ☐ Widowed 4 Ď Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United Auto Workers Union Rep. permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, since 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances Lynch Harris George Harris ၀ 19a. Informant's Name/Relationship (Type, Print) Linda Green 19b Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zin Code) 21502 daughter 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Zion Reformed Church Cemetery 1/10/2007 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furthrad Service Ligensey 22. Na Scarpettis Furiettal Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 Find Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thou, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONCESTIVE Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 My nknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has birector, page 2 s 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ours after death. leral Director: After this c filled in by the funeral dire 1 🗌 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at / Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road Cumberland MD 21502 Harjit Sidhu M.D 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. U 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** A^{M} January 1, 2007 0925 Anna Pearl Hollenbaugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 228 Locust Lane E1kton 8. Date of Birth (Month, Day, Year) OCT 17, 192 If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 💢 F Yrs 1922 Pennsylvania Director 186-12-4084 Usual Residence of Decedent Pages t and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Instit if tem 27 ie marked other than "natural", or items 23e or 28e-f ehow ans: if item 27 ie marked other than "natural", or items 23e or 28e-f ehow any or other traumatic event, in a Medical Espainian must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 ie marked othar than "natural", or items 23a or 28a-f ehov traumatic event, tre Medical Examinar must be notified at 1 √ Yes 2 No Director Maryland Cecil E1kton 10f Zip Code 10g. Citizen of What Country? 10e Street and Number 228 Locust Lane 21921 United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 10 Laundress Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carrie Bolan Lenus Elmer Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Johnson/Daughter 10162 North Highway 3, Louisa, Kentucky 41230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Completer, crematory or other place
North East
Methodist Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January 4, permit. Page Depertment of Important: If eny injury or once. 2007 North East, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Coronar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cete hes been sig , pege 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2€ No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this After th 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Japitar Jahren Henrick After June 10 J 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of thury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide of the Funeral Dr. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 John A. Billon, 40 5+

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

O NAL

9 2007 2. Registrar's Signature

		•	For State Registrar	Otale of Me	•		ficate of	Death		Reg. No.		00000
			Decedent's Name (First, Middle, La.	st)					2. Date of De	ath Day	y Year	3. Time of Death
	Physicia /Medic		Katherin		ardest				Jan.	4,	200 ^{Year}	1:05P.M
	Examin		4a. Facility Name (If not institution, give street and number)					Location of Death		_	County of Death	
			Dennett Road 5. Social Security Number 6. S		HOME (In yrs. last birt	hday)	Oakla If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th.	arrett 9. Birth	olace (State or Foreign
	Funeral Director		234-92-7609 Usual Residence of Decedent	□M 2XF		Yrs.	Months Days	Hours Min.	12/01	/19	53 Mary	Tand
	wo a		10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits
	Mary Internation	ţō	WV Prest	on	Aur	ora	L					1 ☐ Yes XXNo
	deeth with the Marylend bms 23a or 28a-f e how ir man be routted at	irec	10e. Street and Number 10f. Zip C				10f. Zip Code 10g.				izen of What Cou	ntry?
	th wit	alD	Rural Route 1				2670			US.		
	be filed within 72 hours after deeth with the Marylen tel hygiene. d other then "naturel", or frems 23s or 28s-f show event, the Medical Exaction count be rediffed at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Tes Sive A If Yes, Give A Year or Dates:			as Decedent of H fes, specify Cuba ☐ Yes 2 【X] No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	D-	14. Race - Ameri Black, White, Specify: Wh:	etc.
ဂ ဂ	72 ho natur dical	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decede (Give ki	nt's Usual Occup nd of work done	oation during most of work d)	ring	16b. K	ind of Business/Ir	dustry
Maryland 21215-0036	within 72 ene. then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) H.c		aker	D)		Ow	n Home	
N	e filed v		17. Father's Name (First, Middle, Last)	1 110	JIIIEII	Idkel	18. Mother's Nam	e (First, Middle	_		
ä	Mentel Merked o	To Be	David Calvin	Hardestv				Beulah	Juani	ta S	Slaubau	gh
<u></u>	should Mind Mind Mind Mind	F	19a. Informant's Name/Relationship (19b	. Mailing	Address (Street	and Number or Rui	ral Route Numb	er, City o	or Town, State, Zij	Code)
	ss 1 and 2 of Heelth e Item 27 is r other train		David Hardesty	/brother				Ave. Fr				
Baltimore,	permit. Peges 1 and 2 should by Deperment of Heelth and Mente Important: if item 27 is marked ent injury or other traumatic a DRE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		Su nse Garde	ns		ory 01/0		Kir	ocation - City or T	
Balt	permit. Depertrimports eny inje		21. Signatule of Funeral Service Lice	linkle		H P	inkle l .O. Bo	Funeral x 186 [Home, avis,	Inc WV	26260	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not enter	the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician	8 (Immediate Cause (Final disease or condition		rian	ca	ncer					Onset and Death 3 Nowth 5
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						
	LAMITHIE	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):							_		
_	ted nsit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):								
~ `	execu n end lal-tre	Examiner	resulting in death) Last									
68760,	ificate be executed g physiclen end as the burlal-trensit	edical	,	d								
			IF FEMALE:	23c. If yes, outcome	of oromonous					T	22d Date of dolla	
Vital Records, P.O. Box	The law requires that the deeth certificate be executed the bas been signed by the ettending physicien are pege 2 should be detached for use as the burial-trensit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death		Ectopic pregnanc Other (specify) _	у			23d. Date of delik Month	Day Year
σ.	thet t	P.	Part II. Other significant conditions	contributing to death b	out not resulting i	n the und	derlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds	quires n sign ald be	d by	hepotic	Cirrhosis					10	Yes 2	No 3□Pro	bably 4 Unknown
00	sw rec s bee	Completed	,						24a. Wa	s an		opsy findings available ompletion of cause of
Be	The lav	E								ormed?	death?	
ita		BeC	25. Was case referred to medical examiner?					26. Place of Dea				
>	Physician: rthis certific rel director,	5	1 ☐ Yes 2 ☑ No		ent 2 ER/O			her: 4 Nursing H				ify)
0	ing Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Inju Wo M 1	nyat ork?]Yes 2 ∐No	28d. Describe	now inju	ny occurred	
s S	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not	De Diace of In	iury - At home fa	arm stre	et, factory, office		28f. Location	(Street a	nd Number or Ru	ral Route Number,
Division of	s efter of Direct of in Direct of in by	Certification;	4 ☐ Homicide determined	building, e	c. (Specify)	21111, 3410	ot, radiory, other		City or To	own, Stat	'e)	
	To the Hospital or Attending Is within 24 hours effer death. To the Funcel Director: After completely filled in by the funer	Medical (29a. Certifier (Check only one) (Check only on								stated. to the cause(s)	
	within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Da	ate signed (Month	, Day, Year)
		F	Malurs	Marian	- h	11)	りし	0025	139	Janu	ory 4, 20	00/
	6		30. Name and address of person who	, mobile M	death (Item 23a)	(Type, F	247,	Acciden	+ MD	12/5	720	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 9 20	Regist 107	rar's Signature	Son	de					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5<u>,</u> RALPH JONES JANUARY 2007 1:00 A.M/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/5/1925 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Days Hours Yrs. 213-20-2088 Director 81 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f ahow traumatic avant, the Medical Examinar must be notified at Director 1 Yes 2 No MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3153 Rocks Chrome Hill Road 21084 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Dayes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours atter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Harford County Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Highways 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be finent of Health and Mental I that: If item 27 is marked o Giles Harding Jones Alice Louisa Knopp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Catherine L. Jones/Wife 3153 Rocks Chrome Hill Rd. Jarrettsville.M 20a. Method of Disposition
1 ♣Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Peges
Depertment of the transcript if its any njury or of once. Baptist View Cemetery 1/8/2007 Forest Hill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeyal Strvicer Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Respiratory Arrest **Physician** disease or condition resulting in death) /Medical Due to or as a cons quence of) Examiner Pneumonia 2 weeks Sequentially list conditions, if any, bearing to inhamiliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and shed for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, $otinarphi_{\mathcal{S}}$ c. Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 3 Probably 4 □Unknown 2 No 1 Tyes Yarkusan's Disease 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural s after de--al Director: After -vv the tv 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0063981 2007 M.D-5 30. Name and address of pason who completed cause of death (Item 23a) (Type, Print) DR. BENJAMIN LEE 669 REVOLUTION STREET - HAVRE DE GRACE, MD. 21078-3319 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		For State Registrar	State of Mary			lealth and N	lental Hyg	giene 007	00395
Physicia		1. Decedent's Name (First, Middle, Last Margaret Lo	ouise	Jackle			2. Date of Dea Month	Day Yea	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Cumberl	Location of Death	01 0	4c. County of D	eath
Funeral	ni ²	New Hope Assisted 5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 1	Birthplace (State or Foreign
Director		218-12-5244 Usuat Residence of Decedent	^{™ 2} XF 84	Yrs.			Aug 29	, 1922	MD
Marylan f ehow	or	10a. State 10b. County Allegan	cation erland				10d. tnside City Limits 1 √ Yes 2 No		
or 28a-	Funeral Director	10e. Street and Number			10f. Zip Code	24500		log. Citizen of What	Country?
death w me 23a	erai	11609 Bierman Dri	12. Was Decedent Ever	in U.S. 13, \		21502 ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		merican Indian,
ours after	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	Hican, etc.)	Specify: W	
ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. In of Heelth and Mental Hygiene. In the maryla marked other then "natural", or fleme 23s or 28s-f show or other traumatic event, the Madical Exam natural be notified.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occupi kind of work done o DO NOT use retired	during most of work		16b. Kind of Busine	ss/Industry
e filed vall Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last)		Clerk			e (First, Middle,	Maiden Sumame)	
lai y lailla 2 12 2 should be filed with and Mental Hygiene Is marked other the sumatic event, Item	ToE	Albert E. Beckm		19h Mailin	a Address /Street		(Matt) B		e Zin Code)
, svica and 2 sl selth an n 27 ls r er traur		Katherine Pannone	e niece			ie	Cumb	r, City or Town, State erland	MD 21502
Deficiency, We permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is eny Injury or other training.		20a. Method of Disposition 1 Buriat 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispo cemetery, cren Rocky Gap	natory or other plac	(e)	1/8/2007	20c. Location - City Flintstone	
permit. Departn Imports eny Inju		21. Signature of Funeral Service Licens	MA	(22		is Facility is Funeral Ho		and, MD 215	502
		23a. Pari1. Enter the disease, or composition of heart failure. List only	lications that caused the ne cause on each line.	death. Do not ent					Approximate tnterval Between Onset and Death
Physician /Medical		Immediate ^t Cause (Final disease or condition resulting in death)	a. CORONA(24 ART	ERY D	155452			3 4125
Examiner	10	Sequentially list conditions,	b	insequence of):					
be executed sicien end burial-transit	Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
te be executed ysicien end le burial-transit	ical Ex	resulting in death) Last	Due to (or as a co	insequence of):					
leath certificate ettending phy		tF FEMALE:	22a Huas autooma of p					23d. Date of	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: Hele this certificate has been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	in the past 12 months? 1 Yes 2 Mo 4 Pregnant at time of death 5 Other (specify)						
uires that the despise of the eld be detached for	þ	Part It, Other significant conditions co	entnbuting to death but no	ot resulting in the u	nderlying cause give	en in Part I.		/	e to the cause of death?
ne law requir has been si ge 2 should	Completed		sy prior death	24b. Were autopsy findings available prior to completion of cause of death?					
vician: Thi	Be Co	25. Was case referred to medical examiner?				26. Place of Dear	1 ☐ Yes th (Check only or		/es 2□No
ding Physician: The ding Physician: The h. After this certificete hi funeral director, page	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	1 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)					
of Cattendi after death. Director; A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - building, etc. (S	At home, farm, str Specify)		Yes 2 No	28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	edical Ce	(Check only 2 Medical Exam	sician: To the best of miner: On the basis of exa	amination and/or in:	n occurred at the tin	ne, date and place, pinion, death occur	and due to the c	ause(s) and manner late and place, and d	r as stated. due to the cause(s)
To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	29d. Date signed (Me	onth, Day, Year)
		Makustani	1. 1. Jan	era (f)	10 0-	14865		JAN. 3 KD	2007
4		30. Name and address of person who of SUO MEMORIAL	AV5 (NUBSAL		11. 21	502	,	
Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 201	Registrar's	Signature	ule)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

00396

			1 - State Registrer	State of Mar	ryland /		irtment o <i>tificate d</i>				jiene leg. No.	.007	00330	
Pr	nysicia	an	Decedent's Name (First, Middle, Last) Ruth	Pauline		Lo	ong			2. Date of Dea January		200 7 °ar	3. Time of Death 1:22 am M	
	Medic xamin	_	4a. Facility Name (If not institution, give street and number) 8412 Vision Lane					4b. City, Town, or Location of Death Walkersville 4c. County of Death Frederick						
Fur	neral		5. Social Security Number 6. Sex	7. Age	(In yrs. last		If Under 1 You Months Da	ar If Under		8. Date of Birth Sep 7	1		place (State or Foreign Tand	
D	ector		Usual Residence of Decedent	1 -	71	Yrs.				sep /,	1933			
Marylar -1 ehow	lied at	tor	Maryland Frederic		10c. City, To		sboro						10d. Inside City Limits 1 Yes 2 No	
with the	the not	i Direc	10e. Street and Number 655 West Adam Cir	cle			10f. Zip Coo	21798	3		l0g. Citize	en of What Cou	ntry?	
pormit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.	infrar mus	/ Funeral Director	1 Never Married 2 Married	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 💆 No	ver in U.S.		Vas Decedent Yes, specify (ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White	, etc.	
2 hours	ical Exa	ted by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates:	16	6a. Deced	ent's Usual Oc	cupation		20		d of Business/Ir	nite ndustry	
within 7 jene.	The Mad	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))		kind of work do DO NOT use re nemaker	tired)	LOF WORK	, rig		Own Hom	ie	
uid be filec	tic event,	To Be C	17. Father's Name (First, Middle, Last) Lester Erwin	Beall					or's Name ldred	(First, Middle, Pau	Maiden S line		her	
d 2 should be strong of 1 and 1 and 1 2 strong of 1 and 1 strong of 1 and 1 an	treum		19a Informant's Name/Relationship (Type Virginia A. Oland,	Daughter	. 1					Route Numbe Kersvill				
Pages 1 ar nent of Hea	or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ceme	terv, cren	sition (Name on atory or other Cemete	place)	_	2007		ation - City or T	own, State Maryland	
ermit. Pa	eny Injury Once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service License	20						P.A. Fu				
405	: 5 a		23a, Parti Enter the disease, or complice shock, or heart failure. List only on	ations that caused the		1(06 East	Church	ı St,	Freder	ick,	Maryla	nd 21701 Approximate Interval Between	
Physi /Med	ician dical		Immediate Cause (Final disease or condition resulting in death)	Extensiv	ve non	n-sma			_	_			Onset and Death months	
Exam		_	Sequentially list conditions, if any, leading to immediate	Due to (or as a										
od de de	transit	Examiner	rrany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cresulting in death) Last		·									
cate be executed	he burial	dicai Ex	destring in deathy Last	Due to (or as a	consequenc	ce or);								
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours elfter death.	should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal dea	ath 3□	Ectopic pregn				23	3d. Date of deliv	ery Day Year	
Fes that	be deta	Ď	Part II. Other significant conditions con C.O.P.D.; Hyperte	_		_		-	l.			cco use contribute to the cause of death?		
w requi	should	Completed	A.S.C.V.D.	iistoii, iiy	percin	71030	Lania			24a. Was	in		3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of	
n: The li	r, page										med? 2⊠No	death?		
ysicients	directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2□ER/	Outpatien	t 3 DOA	Other		n <i>(Check only or</i> me 5 ☐ Resid		Da Mother (Speci	nughter's Home	
nding Phy Ith.	funeral		27. Manner of Death 1. X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28t	b. Time of Injury		njury at Work? 1 □ Yes 2 □		28d. Describe h	ow injury	occurred	riome	
ol or Attens of tar dea	d in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								al Route Number,			
e Hospit	letely fille	edical (29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin		examination									
To th	comp	Me	29b. Signature and fittle of certifier	1	- 41	2		ense number	0.0	-	9d. Date	signed (Month,	Day, Year)	
	0		30. Name and address of person who co				Print)							
	Sta	<u> </u>	P. Gregory Rausch	, M.D., 50			eventh	Street,	Fre	derick,	Mary	yland 2	1/01-450/	

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edward George January 2,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8275 Verne Place Welcome Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min. (Month, Day, Year) September 9,1922 **Funeral** 1 €M 2 □ F 577-28-7905 84 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28s-f ehow the Medical Examiner must be notified at MD Charles Welcome 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8275 Verne Place 20693 USA 12. Was Decedent Ever in U.S. Agned Forces? 1∕C Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction/ Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be f nent of Health and Mental I int: If Item 27 Ie marked o James Woodward Lloyd Gertrude Ann Moreland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8275 Verne Place, Welcome, MD 20693
of Disposition (Name of Date Date 200. Location - City or Town, State Gladys Lloyd/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition I

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. Fort Lincoln Cem. 1/10/07 Bladensburg, MD 4 □ Donation 5 □ Other (Specify) M00945 21. Signature of Funeral Service Licensee ²². Name and Address of Facility Arehart-Echols Funeral Home, P.A. C. ピークル 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Heart **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by tha e d be detached f 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 2 - No tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11855 Holly Lane, # 107 Waldorf, MD 20601 Nalin Mathur, M.D. 31. Date filed (Month, Day, Year) State JAN 0 9 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MULKEY Month MONTIE 2007 01 04 1743 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1**□M 2□F Jan 28, 1934 Country 369-26-2491 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Cumberland MD Allegany X ☐Yes 2☐No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be 21502 USA 568 Fayette Street Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23sury or other traumatic event, the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married X2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed a/c & heating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edyth Moody Mulkey Lawda O. Mulkey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 568 Fayette Street Cumberland MD 21502 wife Nancy Mulkey Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State scarpelli Funeral Home, P.A. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1/5/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F Ineral Service License 22. Nam Sand Add Ins Fun Brilli Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Dant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Sudden **Physician** avdiac 250W- 1HR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Mary Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performa 1□ Yes 2 **X** No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 2 R/Outpatient 3 DOA 1 Yes 2 No Certification: To 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after dearh.

To the Funeral Director A
completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

State

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

026907

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 1230 РМ January 1, 2007 Anthony Merida, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Ceci1 Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT 22, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 ☐ F Yrs. Director 400-38-6608 76 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Example than the notified at 1 ☐ Yes 2 ☐ No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Sycamore Road 21921 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Manufacturing other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill trent of Health and Mental H tant: If item 27 Is marked other Be Nancy Bargo Anthony Merida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene Merida/Son 25 White Pine Court, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Gilpin Manor January 5, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. injury or 2007 Elkton, Maryland Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland Brister 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KESPIRATO DY FYRLURE JUE P ASPIRATION PAGROOM /Medical Due to (or as a consequence of): **Examiner** SEPJIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto for as a consequence of) burial-transit CENA FAILURE ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, く Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10064670 2007 011011 - M.D. 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) W MONIQUE PRATT - UBUNAWA MD 32. Signature BOW ST. ELKTON, MD 106 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 00400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2007 **Physician** January 2:15 p. ROSA **EDNA** MICHAEL /Medical 4b. City. Town, or Locetion of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Washington Julia Manor Nursing Home Hagerstown If Under 24 Hrs. 8. Date of Birth Hours | Min. (Month, Dey, Yeer) Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Deys 1□M 2♥F 16, 1928 Feb. Maryland Director 78 207-22-2301 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith end Mentel Hygiena. Important: If Item 27 is marked other than "natural". or 16-17 any injury or other traumetic evant 10d. inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 ₹☐ No Funeral Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18010 Putter Drive 21740 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ^X Yeer or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond С. Beans Mary Edna Pryor 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1004 View Street, Hagerstown, MD 21742 Bernard Michael / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Paul's Lutheran 1-8-2007 Myersville, Maryland 22. Name and Address of Facility 21. Signature of Furieral Service Licensee 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Pert 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardinascular Diseace Examiner Due to (or es e consequence of) Physician/Medical Examiner attanding physician enforts as the buriel-transit Hospital or Attending Physician: The law requiras that the daath certificate be axec ted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated according to the control of the c Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown ate has been signed by page 2 should be detac 1 Tyes 2 No Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tyes ours efter deeth.

eral Director: After this cartifica filled in by tha funerel director, I edicai Certification: To Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral D completely filled † Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 0(2323 01-04-2007 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 12 Muhammad Khlid Waseem, MD., 1126 Opal Court, Hagerstown, Maryland 21740 31. Dete filed (Month, Day, Year) 327 Registrer's Signature State JAN 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For FH G863 1/10/07 Graphificate of Death Registrar Amend #5 Per FH G863 1/10/07 Graphificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY CAROLYN HEATON Day **Physician** MORCOCK 8:00A 2, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) S214-48-8670 **Funeral** 1 □ M 2 X F 94 Oct. 11, 1912 Washington, DC Director 214-48-4870 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 No Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ns 23a or ? must be n 8226 Morning Dew Court 21702 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Fremis Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armistead Washington VanDevanter Fannie Morton Edmunds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Morcock, son 8226 Morning Dew Court, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/3/2007 Smithsburg, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature o Funeral Service License M00999 106 East Church Street, Frederick, MD 23a. Part 1 The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Caus (Final disease or andi on resulting in deal) Physician neumonic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) P.O. Box 68760, as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ρ Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, been signe should be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 performed? Yes 2 No 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in within 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier leigh Williams MD BW 9270290 1/2/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Memorial Hospital Day year 32, begistrar's Signatur AN 0 5 2007 31. Date filed (Month JAN 0 5 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 7:03 PM **Physician** Nycum ,2007 Margaret anuary Nellie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland Lions Manor Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 8, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 214-07-2358 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County r than "natural, or items 23s or 28e-f show the Medical Examinar must be notified at Cumberland X☐Yes 2☐No Allegany MD Director 10g. Citizen of What Country? 10f Zin Code 10e Street and Number USA 21502 731 Columbia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 Tes 2 No Specify white Maryland 21215-0036 ģ Y□ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) S.T. Little Jewelry Co. salesclerk and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Herpich Siefers Joseph Siefers 2 or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Morning Dove LN SE Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 le
any Injury or other trau niece Barbara Lyons Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place SS Peter Paul Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Na Scarbellis Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Advanced Dementia one year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, $\mathcal{L}_{\mathcal{L}}$ Due to (or as a consequence of) physician Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 Natural
2 Accident 5 Pending 1 🗌 Yes 2 No after death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) B

DHMH 17 Rev 1/2001

State Registrar Wonsock

31. Date filed (Month, Day, Year)

yeum, Nellie

MD

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JAN 4:55 Ам WOODROW 2007 NELSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BEVERLY HEALTH CARE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country)
 WV Funeral 1 M 2□ F 234-54-9721 77 Director 11/18/1929 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD WASHINGTON HAGERSTOWN 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 750 DUAL HIGHWAY 21740 deeth v USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **AGRICULTURE** ORCHARD WORKER 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be 99 and Mental HOMER L. ORR VIRGINIA W. JOHNSON ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s' If Heelth a' item 27 i SARAH ORR SHELL/AUNT 1183 SHEPHERDSTOWN ROAD, MARTINSBURG, WV 25404 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of H permit. Pages Depertment of Important: If it eny Injury or o Burial 2 □ Cremation 3 □ Removal from State TRINITY LUTHERAN CEMETERY |1/8/2007|RFD, MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, Charles M. Drouen <u>327 W. KING ST., MARTINSBURG, WV 25402</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or attending physicien end for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, page 2 should be 420 phrence 1₽ es 2□No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2□ No 1□ Yes 2 2 No After this certifications funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural s after dec-el Director: Atte 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours all To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tuo address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and L. COPPECES , uno 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Month **Physician** Jan 5, 2007 **Piper** Arveda 1:35am /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Beverly Living Ctr. of Cumberland Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Jul 13, 1919 Months Days Hours 1 ☐ M 2 🔀 F "MD 215-18-8541 **Director** 87 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or items 23a or 28a-f shov It e Medical Examinar must be notified at Oldtown MD Allegany 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21555 USA 20816 Oldtown Rd, SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker . Pages 1 and 2 should be filed vitment of Health and Mental Hygie tent: If item 27 Is marked other to jury or other treumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Effie (Hartman) McCabe Michael McCabe Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20816 Oldtown Road SE Oldtown MD 21555 William Piper son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 □Cremation 3 □Removal from State permit. Page Department o Importent: If any injury or Sulphur Springs Cemetery 1/9/2007 Oldtown MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signal re of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 n. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, froct, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athenselentic Pnysician /Medical Due to (or as a consequence of 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 2 No 1 TYes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 → Ho 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Examiner physician and the burial-transit The law requires that the death certificate be executed P.O. Box 68760. attending p the Records, has Division of Vital the Hospital or Attending Physicien: After death. Director: within 24 hours after To the Funerel Direct

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

Baltimore.

or 28a-f show

29a. Certifier (Check only one) 29b. Signature and title of certified

29c. License number

Certifying Physician: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 5,2007

30. Name and address of person 31. Date filed (Month, Day, Year)

327 Registrar's Signature

3

State Registrar

cal

			For	1 icasc		of Marylar	nd / Depa	artmen	t of H	ealth a	and Mei	-	giene	2000	7 no!	.05
			- State Registrar	(m*) 0 8* 4 -4 . 8			Ce	rtificat	e of L)eath		Date of Dea	Reg. No.		3. Time of	Dooth
	Physici	an	1. Decedent's Name			0.14					1	Month Nuary	Day	2007	r	OP M
	/Medi	7.7	Ann Cr					4b. City,	Town, or	Location of		iiuar		County of De		UP
4	Examir	ier	Civist							Plat				Cha	rles	
	Funeral		5. Social Security Nu	mber 6.	Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under	24 Hrs. 8. Min.	Date of Birt	th V Year)		Birthplace (State of Country) Maryla	or Foreign
	Director		212-18-5	696	1□M 2XF	86	Yrs.	Months	Days	riodis	Ma	Date of Birt (Month, Da rch 2	28,1	920	Mary1a	nd
	pu &		Usual Residence of I	10b. County		10c. Ci	ty, Town or Le	ocation			-		-	<u>-</u>	10d. Inside C	ity Limits
	Maryli f sho	5	MD		rles		La P								1 ☐ Yes	2X No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Num	ber				10f. Zip	Code				10g. Citi	zen of What	Country?	
1	3a or	ig i	7383 W	oodhav	en Dri	ve			20	646				USA		
2	death	ner	11. Marital Status			edent Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Specif	y Yes or No	-	14. Race - Ar Black, W	merican Indian,	
83	or its	y Fu	1 Never Marrie		1 ☐ Yes If Yes, G	2 ∰No ive		1 ☐ Yes				, , , ,		Specify:	White	
38	ural',	d by	3 Widowed 4	1 Divorced 15. Decedent's E	Year or 0	Dates:	160 0000	dent's Usua	ol Ossuss	ation.			16h Ki	nd of Busine:	ce/Industry	
 _ - _ <u>-</u> -	in 72 i "nai	jete	(Specil	fy only highest g	rade completed)		(Give	kind of wo	rk done d	furing mos	t of working		TOD. KI	ill of busine.	samoustry	
7-5	with Jiene.	Completed	Elementary/Secon	dary (0-12)	$\stackrel{\text{College}}{1}$	1-4or 5+)	Se	cret	ary				Dep	t. of	Agric	ultur
ק	e filec al Hyg othe vent,	Be C	17. Father's Name (F								er's Name (F					
a la	Ments Ments arked	10 6	Edgar	Cranfo	rd					Jes	ssie	Basi	tord	l .		
\bigcap \bigcap Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Madical Examinat must be notified at once.		Shelton	me/Relationship Plume	(Type, Print) r , Sr . / :	Husban	19b. Maili	ong Address O. B	(Street a	15 I	er or Rural R La Pl	ata,1	er, City o √D	20646		
₹.5	then Stem Stem Stem Stem Stem Stem Stem Stem	1	20a. Method of Dispe	osition		20b.	 Place of Dispo cemetery, cre				Date			cation - City	or Town, State	
e E	Page ient o nt: if	ļ.,	1 DXBurial 2 □ 4 Donation	Cremation 3 I 5 ☐ Other (Spec	□Removal from :ify)	State Ch	rist	Chur	ch (Čem¦1	1/6/2	007	ort	: Repu	ıblic,M	D
A Baltimore,	rmit. poartm poorta y inju		21. Signature of Fur	neral Service Lice	ensee	, M009	45 2	² .Aret	daddres	s of Facility	ols I	Funer	a1 :	Home.	P.A	
<u> </u>	8258		Jan	JC.	Ehal			211	St.	Mar	y's A	Ave.	La	Plata	P.A. 20	646
				tailure. List onf	v one cause on	each line.	th. Do not en	ter the mod	e of dying	g, such as	cardiac or re	espiratory a	rrest,		Approxima Interval Bei Onset and	tween
	Physician		Immediate Cause (F disease or condition resulting in death)	Final 1	_a.CA	reson	5 m B	· et (NL	0W	*				in KS	
	/Medical Examiner		resulting in death)	•	Due to	(or as a conse	quence ol):									
		ē	Sequentially list con if any, leading to imi cause. Enter Under Cause (Disease or in	ditions. mediate	b. Due to	(or as a conse	quence oi).									
li.	uted d ansit	Examiner	cause. Enter Under Cause (Disease or in that initiated events	tying njury												
P.	eath certificate be executed attending physicien and for use as the burial-transit	Exa	resulting in death) L		Due to	(or as a conse	quence of):									
876Ő	cate be ohysicie the bur	dical			d										-	
89 x	ding p	Me	IF FEMALE:		23c. If ves. or	utcome of pregr	nancv							23d. Date of	deliven	
Вох	atten atten I for u	Physician/Med	23b. Was decedent in the past 12 r	months?	1 Live	birth 2 ☐ Fet nant at time of	aldeath 3	⊒Ectopic p						Month		Year
P.O.	t the d	hysi	1 ☐ Yes 27 9 ☐ Unknown	ÍMO	9□ Unkr	nown										
a.	ires that the de signed by the a f be detached f	by P	Part II. Other signifi	cant conditions	contributing to	death but not re	sulting in the u	underlying o	ause give	en in Part I					to the cause of	
ord	w require been signature	ted											Yes 2	1	Probably 4 🗌	
Rec	The law requires that the death certifical set has been signed by the attending phy page 2 should be detached for use as the	Completed										24a. Was autor perfo		death		available cause of
ta	ician: Th certificete rector, pag	a a	25. Was case referr	ed to medical	1					26 Place	ol Death (0	1 ☐ Yes	2tz No	1 L Y	es 2□No	
<u> </u>	Physician: this certificant	To B	examiner?	No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 D	Othe	25				6 □Other (S	pecify)	
O E	ding Phys h. After this funeral di	in C	27. Manner of Death		28a. Date (Mo	of Injury oth, Day Year)	28b. Time of Injury	of 2	28c. Injun	at k?	280	d. Describe	how injur	y occurred		
Si	Attending r death. sctor: After by the funer	catio	2 Accident	investigati	he -			М		Yes 2						
Division of Vital Records,	after d Direct Direct	Certification:	4 Homicide	determine	28e. Plac	e of Injury - At I ding, etc. (Spec	nome, farm, st ify)	treet, factor	y, office		281	City or Tol	Street an wn, State	d Number or)	Rural Route Nur	nber,
	To the Hospitel or Attendition 24 hours after death within 24 hours after death. To the Funerel Director: A completely filled in by the tr	Medical C	(Check only	1 Certifying F 2 ☐ Medical Ex	aminer: On the	basis of examin	owledge, dea ation and/or in	th occurred	at the tin	ne, date ar pinion, dea	nd place, and ath occurred	d due to the at the time,	cause(s) date and	and manner	as stated. fue to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and	title of certifier	and ma	nner stated.	10-6	29	c. License	e number			29d. Dat	te signed (Ma	inth, Day, Year)	
			1/2	MX	Ma	11	VM			12	06'	9		1131	0 /	
	40		30. Name and addre	ess of person wh	o completed car	use of death (Ite	т 23а) (Туре	Ptint)	N. () .C	NA	LOOM	rex-	M	X 201	03
	St Regist	ate	31. Date filed (Mont	h. Day. Year)		Registrar's Sign	nature	R.								
	negisi	ı al »	07111			7	1									

			State of Maryland 1- State Registrar	/ Depa		t of H	ealth a		ental Hyg			00406
	5		Decedent's Name (First, Middle, Last)						2. Date of Deat			3. Time of Death
	Physici /Medic		MARY ALICE POOLE						January	, Day	200 ^{Year}	6:00 p.M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location o	f Death		4c. (County of Dea	
	3 6	5	Washington Adventist Hospital				Park				ontgome	
h we	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last 78	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min	B. Date of Birth (Month, Day, pril 23	, 19	9. Bir Cc Ma	thplace (State or Foreign buntry) aryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	own or Lo	cation							10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgomery Gai	thers	burg							ty∑Yes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip				1	0g. Citiz	en of What Co	ountry?
	ath w	rai	101 Odend Hal Road			:0877					USA	
920	d within 72 hours after death with the Maryland jiene. I then attrait, or iteme 23s or 28s-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Daties:	1	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		4. Race - Ame Black, Whit Specify: Wh	te, etc.
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	dent's Usua kind of wor DO NOT us	Occupa	ition	of working		16b. Kin	d of Business	/Industry
21	within ene. then	mpje	Elementary/Secondary (0-12) College (1-4or 5+))	or working	1	0		
2		ပိ	12 17. Father's Name (First, Middle, Last)	Hom	nemake	r	18 Mothe	r's Name /	First, Middle, M		n Home	•
Maryland 21215-0036	be d la be	To Be	Jesse Ricketts				He1	en M	obley		,	
	nd 2 lith a 27 is r trai								Route Number yersvil			Zip Code) and 21773
Baltimore,	Pages 1 arent of Hearnt: If Item		117 Burial 2 Cremation 3 Removal from State	etery, cren	sition (Nam natory or ot Luth	her place		Da an.6,			ation - City or sville :	Town, State Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Fundal Since lice lice lice lice lice lice lice li		. Name and						n Stree	et 0 21773
			23a. Part1. Estel the dis-user or emplications that caused the death. I shock, or heart failure. List only one cause on each line.									Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	- 1	on		Fau	ens) .			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as consequent	ce of):	ear	0.	-0	I	iya	C	mg't	
	pa is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ce (f)	1	- ac	-		7 7 20		7	
و. ک	be executed sician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequent or consequen	COM	11	710	ry		NJES			
8760,	2 2 9	dicai	d	1			1					
Box 68	The law requires that the death certifical le has been signed by the attending phy lage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 2 No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3 □	Ectopic pre					23	3d. Date of del Month	livery Day Year
0	at the by the tacher	hys	9 Unknown									
rds, P.	quires than a signed to all the det	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	1	1	o the cause of death?
Vital Records,	he law requir has been s ge 2 should	Completed	Perforated Stom	a C	h				24a. Was ar autops perform	y	24b. Were au prior to death?	utopsy findings available completion of cause of
a	9 11	e Co	25. Was sans referred to medical						1 ☐ Yes 2	No		2 No
Ξ	Physician: this certific ral director,	0 8	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ ER	/Outpatien	t 3 DO	Othe	r	12.00	Check only one		CO# (C	-6.1
of	g Physer this	-	27. Manner of leat 28a. Date of Injury 28	b. Time of		Bc. Injury Work			d. Describe ho			city)
ioi	Attending I ir daath. ector: After by the funer	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	М		? 'es 2 □ N	No				
Division	el or Attendas s after dast la Director: d in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory,	, office		28	f. Location (Str City or Town	eet and , State)	Number or Ru	ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death in 17 of the Functel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, an	d due to the ca	use(s) a ite and p	ind manner as place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier),	29c.	License	number	16			signed (Monti	
	3		30. Name and address of person who completed cause of death (Item 23) RADIHEY SMURAR K	la) (Type,	Print)	50	W	Ed	mons	tor	1 28	
4	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	Good	ا تراجع	14	KL	411		M	P	
100	Registr		31. Date filed (Month, Day, Year) JAN 0 9 2007	Good	W							

00407

Physician /Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 为

Dhusisi		1. Decedent's Name (First,	Middle, Last)				2. Date of Death	D V	3. Time of Death
Physici /Medic		James	Edwin	Rumme	er		Month JANUARY	TH, 200	
Examir	er	4a. Facility Name (If not ins	titution, give street and number	r)	4b. City, Town, or Lo	cation of Death		4c. County of De	
		MEMORIAL HOS			CUMBERLAN			ALLEGANY	
Funeral Director		5. Social Security Number 214–28–6740 Usual Residence of Decede	1 火 M 2□ F	73 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan 19,	1933 9. B	irthplace (State or Foreign
3a-f show tified at	Director	10a. State 10b. C		10c. City, Town or Lo	nberland				10d. Inside City Limits 1 Yes 2 No
23a or 28 ust be no	ral Dire	10e. Street and Number 12318 Willia	ams Road SE		10f. Zip Code	1502	10g	. Citizen of What C	
Department of near an unwinten righter. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Div	If Yes Give	?]No 1050 53	Was Decedent of Hispa If Yes, specify Cuban, N 1 □ Yes 2 □ No S	anic Origin? (Spec Mexican, Puerto R Specify:	oify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify: W	
e. an "natu Medical	Completed	15. Dec (Specify only Elementary/Secondary (0	cedent's Education highest grade completed) 0-12) College (1-4or	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	g 16	b. Kind of Busines	s/Industry
ygrement the true to the true true true true true true true tru	Com	12		Truck	Driver			Constructi	on
arked oth	To Be	17. Father's Name (First, M George V	Vilbur Rummer		18.	. Mother's Name (Mary Lo		iden Surname) nes) Rumr	mer
n 27 is ma er trauma		19a. Informant's Name/Rela	ationship (Type. Print) mmer wife	e 196. Mailir 123	ng Address <i>(Street and</i> 318 Williams	Number or Rural Road S	Route Number, C E Cumbe	ity or Town, State, Erland	Zio Code) MD 21502
lant; If iten jury or oth		4 □ Donation 5 □ Oth		20b. Place of Dispo cemetery, crer Restlawn Me	sition (Name of matory of other place) emorial Garde	ns Da		c. Location - City o	r Town, State
Import any Inj once,		21. Signature of Funeral Se	ervice Liceptsee	22	^{2. Name} scafpense 108 Virgini	น์ก็ยี่เล่ Home a Avenue: C		MD 21502	
attending physician and for use as the burial-transit use as the burial-transit uses	lical Examiner	23a. 7 rt1 Enter the disea hood, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that intitated events resulting in death) Last	b	ad the death. Do not entilline. In the death of the death. Do not entitle the death. Do not entitle the death. Do not entitle the death of the death. Do not entitle the death of the deat		uch as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death 24 Hours
by the attending pached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 1∐Live birth	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
n signed b	by	Part II. Other significant co	onditions contributing to death I	but not resulting in the ur	nderlying cause given in	Part I.	23e. Did tobac		o the cause of death?
To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
certif	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Other	Place of Death (
After this funeral d	\vdash	27. Manner of Death 1☑Natural 5 □Po	1 ☐ Inpati 28a. Date of Inj (Month, Da ivestigation	ury 28b. Time of	28c. Injury at Work? M 1 Yes	28	5 ☐ Residence d. Describe how i	e 6 □Other (Spenjury occurred	ecify)
I Director ed in by the	Certification:	3 Suicide 6 □ C	ould not be etermined 28e. Place of in	jury - At home, farm, stre tc. <i>(Specify)</i>		-	f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
he Funera pletely fille	edical 0	29a. Certifier 1 Cer (Check only Dec	rtifying Physician: To the best dical Examiner: On the basis of and manner st	of examination and/or inv	occurred at the time, d restigation, in my opinio	date and place, an on, death occurred	d due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To t	ž	29b. Signature and title of ce	ertifier		29c. License nur	mber	29d.	Date signed (Mon	th, Day, Year)
4	_	30. Name and address of ne	erson who completed cause of c	teath (Item 23a) /Type 5	D23	3371	Ja	nuary 7,	2007
n			U., M.D., 625			2, CUMBE	RLAND, N	D 21502	
Stat Registra		31. Date filed (Month, Day,	Yea <i>r)</i> 32. Registr	rar's Signature		-, ,			

			State of Maryland / Depa	artment of Health and Martificate of Death	-	enn-	7 00408
	Physici	an	Decedent's Name (First, Middle, Last) ANNA T. RINGGOLD		2. Date of Death Month JANUARY	ay 2 Xe	3. Time of Death
	/Medio	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4 ZU	-
	Examir	er 5	Laurelwood Center	Elkton		Ceci	
	Funeral Director		5. Social Security Number 218-30-1949 G. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Aug 24 1	9.934	Birthplace (State or Foreign Country) Maryland
	yland now		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Ba-fsh	ctor	MD Kent Galena				1 XYes 2 No
	ath with the Marylar 23e or 28e-f show	ral Director	10e. Street and Number 110 West Cross St.	10f. Zip Code 21635	_	.S.A.	t Country?
980	r Itams	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I □ Yes 🌠 No Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
Maryland 21215-0036	within ene. than	Completed	(Specify only highest grade completed) (Give	tent's Usual Occupation kind of work doine during most of workl DO NOT use retired) nts Receivable	Ga Ga	Kind of Busing arment anufac	
yland 2	be filed hal Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last) John Raymond Mulford, Sr.	Hilda H			
	ges 1 and 2 should to f Health and Mer If item 27 Is marke or other traumatic		George R. Ringgold (husband) 1	ng Address (Street and Number or Rura 10 W. Cross St.			
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	sition (Name of natory or other place) Cemetery 1/8/	_	Location - City alena,	or Town, State
Balt	permit. Page Department of Important: If any Injury or once.		21. Surature of it ineral Service Changes M00510 1	Name and Address of Facility alena Funeral F 18 West Cross S	Home of S St. Galer	Stephe	n L Schaech
	Physician /Medical Examiner	er	23a. Part Enter the disease, or complications that caused the death. Do not enter shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I ary, backing to fine distal.	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	edicai Examin	Sequentially list conditions, 1 at y, 1 along to 1 hin collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
.O. Box	that the death certificat led by the attending phy detached for use as the	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.			e to the cause of death? Probably 4 Unknown
al Records,	The ate h page	Completed			24a. Was an autopsy performed?	prior	e autopsy findings available to completion of cause of n?
Vital	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	Attanding Physic death. ector: After this by the funeral dispetal	ation: To	1 Yes 2 No rospite. 1 It patient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date c Injury (Month, Day Year) 28b. Time of Injury	Nursing Hor	me 5 Residence 28d. Describe how inj		Specify)
Division	tal or Attandrs after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plact of Injury - At home, farm, streeth builting, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number o	r Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death can be death from the basis of examination and/or invariant manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause(ed at the time, date a	s) and manne nd place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	29c. License number	29d. D		onth, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	<u> </u>	SJAU	V +
š .	∫ Sta		31. Date filed (Month, Day, Year) 3 Registrar's Signature	HRITHMUS (72	(NEW)	ATTLÉ	DE 19720
	Registr	ar	JAN 0 9 2007 Januar 12 1900				

DHMH 17 Rev 1/2001

SVENTOSKY

STEVEN

ALEX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** Jan 1, 2007 9 40AM Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Beverly Living Center of Cumberland Cumberland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Jun 20, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1918 1 ☐ M 2 ☐ F 233-34-7913 Director 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Machical Examplination and items of the traumatic event, the Machical Examplination and the content of the Cumberland Allegany MD tx☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 110 Mullen Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. markad other than homemaker lown home 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyoi
Important: If item 27 is marked
any injury or other for 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Laura Eliabeth Tennent Palmer Arthur Palmer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11631 Apollo Avenue Cumberland MD 21502 Paul McFarland son 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1/4/2007 MD Rocky Gap Veterans Cemetery Flintstone ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Coronmy /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate 200 No 2 🗆 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan 2, 2007 1)00 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clamberland, MD. 21502 unil Kumar 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-00033 Cynthia Strickland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

yntilia Strickiai		1- For State Registrar	or Maryland /		ficate of Dea			Reg No. 200	7 0041
Physicia ledical Exami		Decedent's Name (First, Middle,La		RICKL	AND		2. Date of De Month January		3. Time of Death 0242 hrs
		4a Facility Name (if not institution, gi Prince George's Hospital	ve street and number)		4b. City	, Town, or Location		4c. County of Deat	
Funeral		5. Social Security Number 6. S		(In yrs. last			der 24Hrs. 8. Date of E	Birth (MM/DD/YYYY) 9 Bi	thplace (State or
Director			M 2 X F	52	Yrs	nths Days Hour		24, 1954 Forei	puntriNEW YORK
any	ł	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, To	own or Location				10d Inside City Limits
Aaryland 28a-f show 1 at once.	ţ	MD. PRINCE O	EORGES			GE PARK	·	10-01:	1 XYes 2 No
th the Mar 23a or 28g notified at	Director	6207 BERWYN F	OUSE RD #	102	101. 2	20740		10g. Citizen of What Cou	nuy/
th with rems 23 at be no	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent E			dent of Hispanic Or	igin? (Specify Yes or N n, Puerto Rican, etc.)		ican Indian, Black,
fter death I", or ite	by Fur		1 Yes 2	X No	1 X Yes	2 No specify	PUERTO RIC	AN Specify WH	ITE
hours a	eted b	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade comp College (1-4 or 5+		6a Decedent's Usu during most of v	al Occupation (Give orking life DO NO		16b. Kind of Business/	Industry
036 vithin 72 ene er than Medical	omple	12			SPANISH	INTERPRI		P.G. DEP'T	OF HEALTH
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other transmatic event, the Medical Examiner must be notified at once	Be Co	17 Father's Name (First, Middle, Last JOSEPH	RAMSEY			18.Mothe	r's Name (First, Middle)		
D 21; should b and Men	5	19a. Informant's Name/Relationship (Type, Print)		10		mber or Rural Route Nu	umber, City or Town, State	
e, MD I and 2 sho Health and item 27 is		MICHEAL STRICKI 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pla	249 GREE ace of Disposition (N matory or other plan	ame of cemetery,	DR., GOLDS	BORO, NC. 2	
Baltimore, permit. Pages I an Department of Her Important: If ite		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify	<i>!</i> :	~ <u> </u>	MBERS CRE	,	1-8-2007	RIVERDAI	E, MD.
Balt permit, Depart Impor		21. Signature of Funeral Service Lice	MY 11 MO	MOO	22. Name a CHAME	nd Address of Facili ERS FUNET	RAL HOME &	CREMATORIUM ERDALE, MD.	P.A.
Physician /Medical		23a. Part I. Enter the disease, or com failure. List only one cause on e	plications that caused that line.	ne death D	o not enter the mod	e of dying, such as	cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Intracerebra Due to (or as a conseq		orrhage				Death
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
_	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
and and transit		d							
760, cate be executed physician and he burial - transit	Medical	X UNPENDED	#23a,PII,2	7, perM	E, g864, 2/1	.2/07 TT		23d. Date of deliver	
ox 687(eath certifica		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at til		2 Fetal dea		ic pregnancy		Day Year
Box 687 ne death certific the attending pred for use as the	Physician/	1 Yes 2 No 9 V Unknow	n 9 Unknown		J Uther (S				
, P.O. res that the signed by be detach	ğ	Part II. Other significant conditions Cirrhosis of liver	contributing to death t	out not resu	ulting in the underly	ng cause given in P		tobacco use contribute to es 2 No 3 Pro	
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director; page 2 should be in by the funeral director; page 2 should be a second or the funeral director; page 2 should be a second or the funeral director; page 2 should be a second or the funeral director; page 2 should be a second or the funeral director; page 2 should be a second or the funeral director.	Completed						24a VVa:		itopsy findings available completion of cause of
tal Reco	Com				-		1 🗸 Yes	ormed? death? 2 No 1 Y	es 2 No
/ital /sician:	o Be	25 Was case referred to medical examiner? 1 • Yes 2 No	Hospital. 1 Inpatient	2 V E	R/Outpatient 3	26.Place of Death	(Check only one) Nursing Home 5	Residence 6 Othe	
ing Phy After th	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day, Yea	2	8b Time of Injury	28c. Injury at Wor	- I	how injury occurred	
ivisior or Attencather death Director:	ertification:	2 Accident Investigat	28e Place of Inui	ry - At hom	e, farm, street, facto	1 Yes 2 ry, office building, e		(Street and Number or Ru	ral Route Number, City
Div spital o hours aft	Certi	3 Suicide 6 Could not determine 29a Certifier 4 2 2 4 5 1 2 2 4 5 1 2 2 4 5 1 2 2 4 5 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					or Town,	State)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending I completely filled in by the finneral director, page 2 should be deached for use as the completely filled in by the finneral director, page 2 should be deached for use as the completely filled in by the finneral director, page 2 should be deached for use as the completely filled in by the finneral director, page 2 should be deached for use as the completely filled in by the finneral director, page 2 should be deached for use as the completely filled in by the finneral director.	Medical	(Check only 1 Certifying Physic						use(s) and manner as stat e and place, and due to th	
F » F »	Me	29b Signature and title of certifier			2	9c License number	-	29d. Date signed (Mo	nth, Day, Year)
		30 Name and address of person who	completed cause of dea	ath (Item 23	3a)	O.C.M.E.		January 3, 2007	
p		Ling Li, MD Assistant M	Medical Examiner	111 P	enn Street, Ba	timore, MD 21	201		
St Regist	ate rar	31 Date filed (Month, Day Year) 20	32 Registrar's	Signature	MARKED				

			1- State of Maryland		artment of H		and Me		iene eg. No2	07	00412
	Physici	an	1. Decedent's Name (First, Middle, Last)				2	2. Date of Dea Month		Year	3. Time of Death
*	/Media	al		wart	zwelder			01	03	07	0636 M
	Examir	er	4a. Facility Name (If not institution, give street and number) WMHS-Braddock Campus		4b. City, Town, or		of Death			nty of Death	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	Cumber1a If Under 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth		legan	place (State or Foreign
	Director		216-38-2049 x ^{1 M 2 F 67}	Yrs.	Months Days	Hours	Min. J	ul ^M 20, ^{Da} 1	939	Cou	PA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, T.	own or Lo	cation						10d Incide City Limits
	Maryla f sho	ō	MD Allegany I	LaVal	е						10d. Inside City Limits X1 □ Yes 2 □ No
	r 28a-	irect	10e. Street and Number		10f. Zip Code			1	0g. Citizen o	of What Cor	untry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must <u>be notified at</u>	Funeral Director	443 Braddock Street		2	1502				JSA	
	r dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Orig	gin? (Speci	fy Yes or No-		lace - Amer	
36	s afte ", or it	by Fu	1 Never Married X2 Married 3 Widowed 4 Divorced 1964-67		I□Yes 2☐No	Specify:		,		cify: whi	
9	thour tural	ed b		6a. Decec	lent's Usual Occupa	tion			16b. Kind of		
215	hin 72 e. an "na Medik	plet	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done do OO NOT use retired)	uring most	of working	'			
2	filed withi Hygiene. other than	Completed	12 50	uperv					C&P T		
und	be fill tal H od oth	Be	17. Father's Name (First, Middle, Last) Richard Lee Swartzwelder			18. Mother Sara	r's Name (First, Middle, Merdew S	Maiden Surn	_{ame)} welde	r
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than "saumatic event, the Mec	ို		IOh Mailin							
	permit. Pages 1 and 2 should be flied within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Ann Swartzwelder wife	443	Braddock	Stree	t or Hurai i	LaVale	City or I on	n, State, M	⁷ 21502
altimore,	es 1 and of Health f Item 27		20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of	, ;	Dat		20c. Location	n - City or T	own, State
Ë	Pages nent of I int: If Ite		1 Burial 2 □ Cremation 3 □ Removal from State Woods 4 □ Donation 5 □ Other (Specify)	Churc	natory or other place th Cemetery	"	1/5/	2007	Colera	ain Tn	shp PA
alti	permit. Pag Department Important: I any injury o		21. Signatur of uneral Septice Licensee	22	. Nam Seat pellit						
<u> </u>			111000 July		108 Virgin					502	
201		a :	23a. Pant. Enter the disease, or compileations that caused the death. Distork, or heart failure. List only one caus, on each line.			, such as o	cardiac or i	respiratory arre	est,		Approximate Interval Between
	Physician /Medical	ĺ	Immediate Ouse (Final disease or condition resulting in death) ADEND CAR		oma ot	FL	LUN	6			Onset and Death ONL YEAR
	Examiner		Due to (or as a consequence	ce of):							
	\$ S _ d	e.	Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury	de of):					_		
ß.	cuted nd ransit	Examiner	that initiated events C.								
ő	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence	ce of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d								
Box 6	res that the death certifica igned by the attending ph be detached for use as t	Me	IF FEMALE: 23c. If yes, outcome pf pregnancy								
ğ	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ath 3□	Ectopic pregnancy Other (specify)					Date of deliv Vlonth	ery Day Year
P. O.	t the c by the achec	hysi	9 ☐ Unknown 9 ☐ Unknown								
S,	ss tha gned l		Part II. Other significant conditions contributing to death but not resulting					23e. Did tob	acco use co	ntribute to f	the cause of death?
Vital Records,	w require been sign	Completed by	CHRONIC OBSTRUCTIVE PUL	MON	ary b	7SE7	ASE	1 ☐ Ye	s 2∐No	3 Pro	bably 4 □Unknown
ec	law ras be	ple	PLEURAL EFFUSION					24a. Was ar		. Were auto	opsy findings available ompletion of cause of
E	cate t	ပ်	<u> </u>					perform		death?	2 □ No
<u> </u>	slcian; The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?		Othor	.,		Check only one			
ō	Phys	<u>ا۔</u>	1 1 1es 2 Inpatient 2 ER/0	Outpatient o. Time of	3L DON	4 L INUR		5 Reside			fy)
on	nding F th. :: After e funera	ţi	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	28c. Injury : Work? M 1 \(\sup Ye	es 2∐N	i	a. Decembe no	w injury occi	ined.	
Division or	er dea rector	<u>ii</u>	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f	. Location (Str	eet and Nun	nber or Run	al Route Number,
ā	ital or rs after ral Dir led in	Certification:	3, 11, 12, 13, 13, 13, 13, 13, 13, 13, 13, 13, 13					City or Town			ļ
	Hosp 4 hou Fune tely fil		29a. Certifier (Check only and only conditions) (Check only conditions) (Check only and only conditions) (Check only and only conditions) (Check only	lge, death and/or inv	occurred at the time	e, date and inion, death	l place, and	d due to the ca	use(s) and r	nanner as s	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		20	d Date sice	and /Manth	Day Year
	۴≯۴°۵		M.	D	7 6	71	18	2	- D	Ta (Month,	7 (50)
	10	-	30. Name and address of person who completed cause of death (Item 23a	a) (Type F	rint)) د_	(0		1		2100
_	V		WIRASAT HASNAN 90	0 5	ETAN	DR	IVE	CVMB	ERL	AND	Day, Year) 2007 , MD 21502
	Sta	-	31. Date filed (Month, Day, Year) 32. Sgistrar's Signatur	(A)	eve						
	Registra	ır	OUTLA P TOOL SANGE	-							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Jan 5, 2007 7:10am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 10, 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months **½**□ M 2□ F МĎ Yrs. 88 217-07-9582 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 3402 Pershing Street 12. Was Decedent Ever in U,S. Armed Forces? ↓ ☐ Yes 2 ☐ No MYes, Give Year or Dates: WW II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Z☐ No Specify: Specify: white ¥ ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer bakery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Suzanne Adams Wilson Richard Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13806 Uhl Highway MD 21502 Cumberland Patricia Squires daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2007 Rose Hill Cemetery MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - of Funeral Service Licen ee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown attensolemner = CUACAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 - Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 **□ N**o 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

ဥ

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examinal must be notified at

Baltimore, Maryland 21215-0020

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

After this certificate has been signed by the attending physician and funeral director, page 2 should be deteched for use as the bunel-transit

Attending Physician: spital or Attending Physhours after death.
neral Director: After this y filled in by the funeral d

To the Hospi within 24 hou To the Funer completely fil State Registrar

24 hours a

4 Homicide 29a Currier (Check only one) 29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

6 Could not be

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

the carifying I hysician: To the best of my knowledge, death oncurred at the time, date and place, and dre to the cause(s) and manner of stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

911Net1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00414 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department of Health Andrew 1- State of Maryland / Department / Department / Department / Department / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Ralph McClellan Wratchford 6:59AM 05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Franklin Square Hospital
5. Social Security Number (6. Sex 7. Age (In yrs. last birthday) Rosedale
If Under 1 Year If Under 24 Hrs. Baltimore 8. Date of Birth
July 31, Year) 932 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Days 152 M 2 ☐ F Months Hours 74 215-30-4503 Director West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21221 10 Judywood Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Wratchford, Rolph M 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 ie marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Inspector Martin Marietta 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Lee Strawman Barnev Wratchford ဥ 19a. Informant's Name/Relationship (Type, Print) (Daughter)b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health a importent: if item 27 ie any injury or other trau once. 145 Leona Dr. Karen D. Brackins-Humes (Sister) Conowingo, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1/9/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, Maryland Harford Memorial Gdns. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home 3399 A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) 24 hrs /Medical Due to (or as a consequence of): Examiner Hypertension 10 yrs Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes t irector, page 2 s autopsy performed; 1 ☐ Yes 2 ☑ No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 VER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ares 105 D62567 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Hager MD, 9000 Franklin Square Drive, Baltimore MD 21737 Dr. David 31. Date filed (Month, Day, Year) State Registrar JAN 1 0 2007 Ballera.

			State of Maryland / Dep	partment of Health and M	-	-	00115
				ertificate of Death	Re	g. No. UU/	00419
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	Frances Bolton William	4b. City, Town, or Location of Death	January	1, 2007 4c. County of Death	0600 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) SunBridge Care Center	Elkton		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthr	lace (State or Foreign
ļ,	Director		222-07-5668 1□M 2\overline{\text{T}} \ 91 \ Yrs.	Months Days Hours Min.	Month, Day,	1915 Mar	yland
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	Maryli f sho	ō	Delaware New Castle Wilmin				1 ☐ Yes 2 🙀 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	th with		117 Edgewood Road	19803		United St	ates
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	
8	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or liems 23a or 28a-f show event, tre M.dicel Exerbit at traist te notified at	Completed by	15 Decedent's Education 16a Dec	edent's Usual Occupation	1	WI 6b. Kind of Business/In-	dustry
215	thin 73	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		
2	ed wii	Соп		omemaker		In Her Own	Home
and	I be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last) Franklin C. McCoy	18. Mother's Name		faiden Sumame)	
Maryland 21215-0036	should nd Me mark matic	ပ္	·	ling Address (Street and Number or Rura		City or Town, State, Zip	Code)
	nd 2 : alth ar 27 is ir trau		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Edgewood Road, Wilr			
ore,	of Head		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, or	position (Name of ematory or other place) Janua	Pate 2	Oc. Location - City or To	wn, State
Ĕ	Pag ment tant: I		`4 ☐Donation 5 ☐Other (Specify) Bethel C	Cemetery 2007	C	hesapeake C	ity, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examination at any injury or other traumatic event, if a Modical Examination at any once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility icks Home for Fune 03 W. Stockton Str	rals, P.	Α.	
	202 0		23a, Part1, Enter the disease, or complications that caused the death. Do not ex-				Approximate
	Physician		shock, or heart failure. List only one caus in each line.	1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	errest			
	Examiner		Sequentially list conditions b. Stroke	·			
d	ad sit	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause Disease or is jury.	1 1			
V2	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	stery diseos	26		
760,	icate be executed physician and s the burial-transit	calE	d				
89	rtificat ng phy i as th		IF FEMALE:				
Вох	ath ce ttendii or use	an/h	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delive	ny Day Year
0.	The law requires that the death certifica ite has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		10101111	ou, ou.
<u>α</u>	res that the igned by be detact	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Records,	quires n sign uld be	ed by			1 ☐ Ye	s 2 No 3 Prob	ably 4 Unknown
000	aw requir is been si 2 should I	Completed			24a. Was an	24b. Were auto	psy findings available
E E	sician: The law certificate has b irector, page 2 s	Com			autopsy perform	led∕? death?	npletion of cause of 2 No
Vital	ding Physician: The h, After this certificate ha funeral director, page	Be (25. Was case referred to medical examiner?	26. Place of Death			SPECIAL SINGLES
of	Physic this c	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manper of Death 28a. Date of Injury 28b. Time		me 5 Resider 28d. Describe how	nce 6 Other (Specify	()
Ou	ding I th. After funer	tlon	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	200. 20001120 1101	w injury cocurred	
Division	l or Attending after death, Director: Afte In by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura	l Route Number,
Ö	ital or A rs after al Directed in by	Cert	building, etc. (Specify)		Ony or Youn,	State	
	To the H' spital or Attene within 24 hours after death To the F, neral Director. completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea (Check only one) And manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
•			I (Slooyeen, MD.	D0006075	6 -	710717	2007
	3		30. Name and address of person was empleted cause of death (Item 23a) (Type O2den COKSONON (MD)	(203)	Ma'u	3-1.81	MO, MD
	Sta Registr		31. Date filed (Mooth, Day, Year) 2007 A Registrar's Signature	arti)			

DHMH 17 Rev 1/2001

State

Registrar

FRANCIS KHOO.

JAN 1

200

31. Date filed (Month, Day, Year)

OSLER

7601

32. Registrar's Signature

DRIVE

TOWSON, MARYLAND 21204

			1- For State of Maryland / De Registrar	epartment of F Certificate of		-	giene Reg. No 2 0 0 7	00417
F			Decedent's Name (First, Middle, Last)		Dodin	2. Date of De	ath	3. Time of Death
14	Physici /Medic		James Alfred Avirett, Jr.			Jan.	Day Yea 4 2007	8:35 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of		4c. County of De	
			Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In vrs. last birth)	Towso	n If Under 24	the long to	Balt:	lmore
	Funeral Director		5. Social Security Number 162-42-6699 X 7. Age (In yrs. last birtho	Months Days		Hrs. 8. Date of Bir Min. (Month, Da Jan. 15	tn y, Year) 9. E	sirthplace (State or Foreign Country)
104	P		Usual Residence of Decedent			Jan. 13) 1949 F	<u> </u>
	arylar show d at	-	10a. State 10b. County 10c. City, Town of	r Location				10d. Inside City Limits
	the M 28a-f notifie	Director	MD Baltimore Cock 10e. Street and Number	eysville 10f. Zip Code			40-07	1 Tyes 2 No
	3a or	I Di	4 Chilhowie Ct.	210	20		10g. Citizen of What	Sountry ?
	death	Funeral		13. Was Decedent of H If Yes, specify Cub		n? (Specify Yes or No	USA - 14. Race - Ar	nerican Indian,
õ	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 M No	1 ☐ Yes 2 ☑ No		Puerto Rican, etc.)		
215-0036	hours ural",	d by	3 Wildowed 4 Divorced Year or Dates:				Specify:	white
<u>5</u>	in 72 r"nat ledica	olete	(Specify only highest grade completed) (C	ecedent's Usual Occup Rive kind of work done fe. DO NOT use retired		of working	16b. Kind of Busines	ss/Industry
	d with giene. rr thar the N	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1 Engineer	-7		Enviroment	al Engrg.
g	be filed within 72 hours after death with the Marylar ttal Hygiene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at	Be C	17. Father's Name (First, Middle, Last)		18. Mother's	s Name (First, Middle,		
<u> </u>	ould be in Mental in Menta	ဥ	James Alfred Avirett, Sr.			na Sarah S		
Maryland 2	ages 1 and 2 should be ent of Health and Mental t: If item 27 Is marked o y or other traumatic eve			ailing Address (Street Chilhowie				
ď	s 1 an F Heal Item 2 other			sposition (Name of crematory or other place		Date	20c. Location - City	
saltimore,	permit. Pages Department of I Important: If ite any injury or ot once.		Zaccination of temoval from state	crematory or other plac rematory	1	/6/07	Catonsvill	
<u>=</u>	rmit. spartm porta y inju		21. Signature of Surera Survice Dicensee	22. Name and Addre	ss of Facility			
<u>n</u>	e a E c		Michael J Flagle	Lemmon Fun 10 W. Pado:	eral Ho nia Rd	ome of Dul Timoniu	aney Valle m. MD 2109	y, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyir	ig, such as ca	ardiac or respiratory a	rest,	Approximate Interval Between
)	Physician /Medical	ĺ	resulting in death)	momA				Onset and Death
	Examiner		Due to (or as a consequence of):					U
i ngit		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury b. Due to (or as a consequence of):					
,	cuted	Examiner	that initiated events					
Ď,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
2	icate t physic s the b	Physician/Medical	d					
X	certifica nding plase as t	//Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				22d Date of d	olivan.
. DOX	siclan: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	iciar	in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date of d Month	Day Year
5	at the by the tache	hys	9 □Unknown 9 □Unknown					
<u>,</u>	res that igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	en in Part I.			to the cause of death?
ecords,	requil een s hould					_ 10\	′es 2 1 No 3 1	Probably 4 □Unknown
i T	has by	Completed				24a. Was autop	sy prior to	autopsy findings available completion of cause of
	n: Th fficate or, pag	S	25. Was case referred to medical			1□ Yes		
>	ysicia s cert	To Be	examiner? 1 Yes 2 No	tient 3 DOA Othe)r:	Death (Check only o	ne) lence 6 Other (Sp	Hasaica
5	ig Phy ter thi		27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injur			ow injury occurred	ecity) (C - g) (C
2	tendlr eath. or: Ai	Satio	2 Accident investigation	M 1 🗆	Yes 2 □ No			
2	or At after d Direct in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
-	spital ours a neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the tin	ne date and r	place, and due to the	cause(s) and manner	ac stated
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my o	pinion, death	occurred at the time,	date and place, and di	ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c, License	_ 1		29d. Date signed (Mor	
			If forthand they, in	D Do	5000		mony ?	,2007
	20		30. Name and address of person who completed cause of death fitem 23a) (Typ.	pe, Print)	ale-	S7. X	loto ind	2120×
	Sta	e	31. Date filed (Month, Day, Year) 33. Digistrar's Signature	10		- I Valent	-,-,-	
	Registra		IAN 1 9 2007 Brown & &	and I				
SLIK	1H 17 Rev 1/20	04						

			for State Registrar	State of Marylan		rtment of		Mental Hy	giene Rag. No.200	7 00418
	Physici		1. Decedent's Name (First, Middle, La PLCHARD	B BRUTO				2. Date of De Month		
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give Willy Law of Man) 5. Social Security Number 6. S 7 13 18 3452	e street and number)	Centre	0 11		ath	4c. County of De	eath Sirthplace (State or Foreign Country)
	D	ector		nore 10c. Cit	y, Town or Loc	ation	un			10d. Inside City Limits
	th with the 23s or 2	Funeral Director	3929 Luma C	ircle		10f. Zip Code	1/33		10g. Citizen of What	Country?
5-0036	ours after dea rsi', or itsms Examinar m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		/as Decedent of Yes, specify Cu □ Yes	Hispanic Origin? Juban, Mexican, Pue Specify:	(Specify Yes or North Rican, etc.)	o- 14. Race - Ar Black, WI Specify:	nerican Indian, nite, etc.
0-61212	be filed within 72 hours after death with the Marylan at Hygiene. All Hygiene. All Hygiene. Somether than "natural", or itsms 23a or 28a-f show avent, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give k	ent's Usual Occ find of work don O NOT use reti	ne during most of w red)	rorking	Barber 3	ss/Industry
Maryland	Me A Series	To Be (17. Father's Name (First, Middle, Last, Somuel Bruto 19a. Informant's Name/Relationship (2	19h Mailine	Addross (Stro	Ollie	Mae !	Barland Barland Per, City or Town, State	Zin Codel
	1 and 2 Health a sm 27 is ther trau		Jeffery Bruton 20a. Method of Disposition	1 Brother 200. P	3929	Lumo ition (Name of	Circle 1	nandall. Date		21133
<u>=</u>	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifical Service Licentifical y) Gre	enmar	atory or other p H Cren Name and Add	1	11.2007 Ternation	Baltimar Servicus	e,mD	
n			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence HODGKIN	uence of):	ympuc	MA			
8/60,	certificate be executed adding physician and use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Agured Due to (or as a consequence to consequence do consequenc	Immi	unode	o cienci	J Syno	Irone	
S. G	the death y the attain ched for i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3□	Ectopic pregnan Other (specify)	осу		23d. Date of d Month	elivery Day Year
rds, P	sign and be	٥	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the und	derlying cause o	given in Part I.		tobacco use contribute Yes 2 □ No 3 □	lo the cause of death? Probably 4 2 Onknown
ř	The ate h	Completed								
		To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA C	inh	eath (Check only of Home 5 ☐ Resi	o <i>ne)</i> idence 6 ⊡Other <i>(Sp</i>	necify)
ion of	anding Physiath. or: After this ne funeral di	ation:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Inj W M 1 (how injury occurred	,,
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify	<i>'</i>)			City or To	Street and Number or i wn, State)	
	A Hosp A 24 hours A Fune Metely fi	edicai	29a. Certifier 1 PCartifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno- niner: On the basis of examinat and manner stated.	wledge, death ion and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and de	as stated. ue to the cause(s)
)	To the Comp	Σ	29b. Signature and title of certifier	110			nse number		29d. Date signed (Mor	nth, Day, Year)
•	7		30. Name and address of person who	completed cause of death (Item	23a) (Type, P		7678		Javi 81	100+
			Smia Blome 31. Date filed (Month, Day, Year)		veen		Balhr	none, n	ND 7/20)
4)	Sta Registr		JAN 1 1 2007	A Programa Signal	house	رع				

	_		1 - For State of Maryland / De Ragistrar	partment of Health and ertificate of Death		ene 007 004	19
	Physic /Med		1. Decedent's Name (First, Middle, Last) Marie A. Bullock		2. Date of Death Month	Day Year 3. Time of D	Death
	Exami		4a. Facility Name (If not institution, give street and number) Heritage Nursing Home	4b. City, Town, or Location of Death	Januar	y 5,2007 5:24 4c County of Death Baltimore	Р "
	Funeral Director		5. Social Security Number 2 18-12-3556 6. Sex 1 M 2 F 8 3 Yrs. Usual Residence of Decedent	Months Days Hours Min	8. Date of Birth (Month, Day, 1) 2-26-19	(ear) 9. Birthplace (State or Country)	Foreign
(0	72 hours after death with the Maryland natural; or Iteme 23a or 28a-1 show dical Examinant be notified at	Funeral Director	10e. Street and Number 6623 Bushey Street	Ore City 10f. Zip Code 21224 3. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert		10d. Inside City 1 Year 2 3. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc.	
d 21215-0036	d within piene. r then *	e Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	1 □ Yes 2 □ No Specify: cedent's Usual Occupation re kind of work done during most of work DONOT use refired) DOKKeeper	U U	Specify: White bb. Kind of Business/Industry S Government	
Maryland	s 1 and 2 should be filed if Health and Mental Hyg item 27 Is marked othe other traumatic event,	ToB	Paul L. Winterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Emma He			
altimore, I	Page nent o int: If iry or		20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition Sacred	ematory or other place) Heartof Jesus	10-07 B	altimore. MD	4
Ba	Departition of the control of the co		23a Part Enter the disease as complications that was districted	22. Name and Address of FacilityBra PA, 2134 Willow	Spring	Road, 21222	ome
68760,	Physician but and but sicial pe executed but sicial street but and street street street street but sicial street s	edical Examiner	shock, or heart failure. List only one cause in a caused the death. Do not ensure that cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	DIAL INF ARTERY ALHYPE	ARCT DISE 2TEM	ASE 127E	PR AR
. Box	death certil e attending d for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 0 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 (4 Pregnant at time of death 5 (9 Unknown)	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Yea	ır
Records, P.	the deded	þ	Part II. Other significant conditions contributing to death but not resulting in the URINARY IRACTION	underlying cause given in Part I.	23e. Did tobacc	200 use continute to the cause of deat	
r	The ate h page	Be Completed	25. Was case referred medical examiner?	26. Place of Leath	24a. Was an autopsy performed 1 Yes 2		ilable e of
VISION OF	ding Phy h. After this funeral d	ertification: To	27. Mann of Death 1	nt 3 DOA Other: wursing Hor of 28c Injury at Work? M 1 Yes 2 No	ne 5 Residence 28d. Describe how in	and Number or Rural Route Number	
	ne Hospita in 24 hours he Funeral pletely filled	ledical C	29a. Certifier Certifying Physician: To the best of my knowledge, deat 2 Modical Examiner. On the basis of examination and/or in and manner stated. 29b. Signal brain and White Certifier	h occurred at the time, date and place, a vestigation, in my opinion, death occurred 29c. License, number.	and due to the cause and at the time, date a		
	6	1	30 Name and address of person with completed cruse bt death (Item 23a) (Type,	D14160	JAN HIE H	IVARYOS, 201)'/
	Stat Registra	•	31. Date filed (Month, Day, Year)	ALTIMORE,	MARY	And -2/225	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf 8863 1-23-07 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 2000 ANUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOPKINS Date of Birth (Month, Day, Year) 11-23-289. Birthplace (State or Foreign **Funeral** Months Days 1∏ M 2□ F Hours Min. Country) MD 78 213-26-1492 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mantel Hygiens. In popartment of Health and Mantel Hygiens. In mortant: I flem 2? Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. MD 1 ☐Yes 2 ☐ No Director Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 959 Dalton Avenue 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No if Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify ģ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical 1.2 electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward A. Bailey Mary E. Pettit 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie S. Bailey 959 Dalton Avenue wife Baltimore, MD 21224 20b. Place of Disposition (Name of cametery, crematory or other place)

Bayview Crematory 1-11-07 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licenses PA, 2134 Willow Spring Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death immediate Cause (Final disease or condition resulting in death) **Physician** DAY DEPSIS /Medical Due to (or as a consequence of) Examiner 14 DAYS BOWEL SCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical as attending asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Por in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Onknown CORONARY ARTERY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 1□ Yes Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Thpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Director: fo the ... within 24 hour. • the Funeral Dire. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Himore, Maryland 21287 400 LOCKMAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

ances,

			1 - For State Registrar	State of Maryla	nd / Dep		f Health and			0.7	00421
	-		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
	Physic /Medi Exami	cal	Treva Margare 4a. Facility Nam <i>a (If not institution, giv</i>			4b. City, Towr	n, or Location of Dea	Jan.		2 0 0 7 ity of Death	3:05 A _M
1			Long View Nurs 5. Social Security Number 6. S	sing Home		Man	chester		Ca	arrol	1
	Funeral Director		5. Social Security Number 6. S 220-16-0464 Usuai Residence of Decedent	7. Age (In yrs	. last birthday, Yrs.	Months Day			v. Year)	9. Birthp Cour Mar	lace <i>(State or Foreign</i> try) yland
	land ow		10a. State 10b. County	10c. C	ity, Town or L	ocation				1	Od. Inside City Limits
	Marylan I-f ahow	ţ	Maryland Carr		stmins						1 ☐ Yes 2 ☐ No
	or 28g	lrec	10e. Street and Number			10f. Zip Code	9		10g. Citizen o	f What Cour	try?
	23a	ai	719 Franklin	Ave.		2115	57		U	.S.A.	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itama 23e or 28e-f ahow event, tra Madical Examinat nous be notified at	y Funeral Director	11. Marital Status 1 □ Nøvør Married 2 □ Married	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give	J.S. 13.	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ N	of Hispanic Origin? (uban, Mexican, Pue No Specify:	Specify Yes or No- to Rican, etc.)		ace - Americ ack, White,	
Ö	hours tural'	ed by	3 XWidowed 4 □ Divorced	Year or Dates:	100				Spec	W	hite
21215-0036	in 72 n nai	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use ret	cupation ne during most of wo ired)	orking	16b. Kind of	Business/Ind	dustry
212	filed within Hygiene. ther ther	E	Elementary/Secondary (0-12)	College (1-4or 5+)			custodi	1	Schoo	ol	
nd	al Hygi al Other vent, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Suma	ıme)	
yla	should be find Mental He marked of	2	Albert Henry	Mancha				Kate B			
Maryland		1	19a. Informant's Name/Relationship				et and Number or A				
	s 1 and 2 if Heelth item 27 i		Martha Knight 20a. Method of Disposition			Frankl sition (Name of	in Ave.	, Westmin			
õ	000-		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other p	, I		20c. Location		•
Baltimore,		li	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen				Cem Jan			+	
Ba	permit. Departr Importa eny Inje		I Hand Ellis	500	3 1	006 Cha	rmil_Dr	ckhardt	Funer	ral C	hapel P.A
		П	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the dea	th. Do not en	er the mode of d	ying, such as cardia	c or respiratory arr	ester,	Ma.	Approximate
	Physician		tmmediate Cause (Final disease or condition	coreba V	ancul	av Ac	cident				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec			Ins di				
	Examiner		Sequentially list conditions.	. periphe	las	Vascr	ilve di	iseuse	-		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	ate be executed hysicien and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):						
200	sicier burig	calE	l	,	, , .						
	ificate g phy as the			d							
Вох	death certifica e ettending ph id for use as th	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Ter			23d. Da	ate of delive	v
B	res that the death certifica igned by the ettending ph be detached for use as th	Physician/Med	in the past 12 months? 1 \(\subseteq \text{ Yes} 2 \subseteq \text{ No} \)	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		Ectopic pregnar Other (specify)	ıcy				Óay Year
P.0	The law requires that the ste hes been signed by the page 2 should be detache	Phy	9 □ Unknown								
	res th	þ	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause (given in Part I.				g cause of death?
Ö	w require been sig should b	Completed						1 L Ye	9s 2□No	3 Proba	bly 4 Unknown
3ec	: The law cete hes l page 2 s	ш						24a. Was a autops	y	prior to com	sy findings available ipletion of cause of
			OF Meaning referred to modified						No	death? 1 ☐ Yes	No No
Ξ		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	IED/O		Ath an	ath Check only on	411		-
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Inj	ury at	lome 5 Reside			
<u>.</u>	Attending r death. •ctor: After by the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		'ork? □Yes 2□No		. ,		
Division	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	est, factory, office	9	28f. Location (St. City or Town	reet and Numi	ber or Rural	Route Number,
0	rel Di										
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	wledge, death	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the ca	tuse(s) and mate and place,	anner as sta	ted. the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.			nse number		9d. Date signe		
	⊢ ≯ ⊢ ŏ) agansusi	ya mo			51705	2.	1 - 9		ω _γ , / cα//
	1		30. Name and address of person who o		g 23a) (Type			1			
	6		m. PANSURIYA	349 ma	Molm	DR	hes	tminste	or a	10 21	157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture A	9 -00 -					

			1 - For State Registrar	State	of Marylar		artment o			-	giene	7	00422
	Physic		Decedent's Name (First, Middle	, Last) Mary	/ Eliza	abeth	Butts			2. Date of De. Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution	4b. City, Town	City, Town, or Location of Death 4c. County of Death					0-2011			
			7801 Peninsul	a Express	sway Apt	t. 315	Dur	nda1k					ltimore
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ar If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	h v Vearl		lace (State or Foreign
	Director		216-28-4488	1 □ M 2 🔀 F	75	Yrs.	NOTION	ys riours	PVIII I.		17,1931		yland
	pur *	1	Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ecation					J	Od Jasida City Limits
	faryla sho ed al	5			, 66. 61	ty, 101111 01 Ec						0d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	28e-1	ect	Maryland Balt 10e. Street and Number	imore			10f. Zip Cod	unda1k	-		10- Chi(1	A/5 - A O	
	with Sa or	ā		Ermyoss	· · · · · · · · · · · · · · · · · · ·	21 5	Tor. Zip Cod		21222		10g. Citizen of		
	Jeath	Funeral Director	7801 Peninsula		edent Ever in U		Was Decedent of					e - Americ	States
10	r Her	臣	1 Never Married 2 Marri	Armed For ed 1 ☐ Yes	orces? 2 ☑ No		Was Decedent of f Yes, specify C	uban, Mexican	, Puerto F	Rican, etc.)	Bla	ck, White,	
8	ours a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve -		1∐ Yes 2⊠i	No Specify:			Specif	/ :	White
5-0	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23a or 28e-f show event, if a Marical Examination and event, if a Marical Examination.	Completed	15. Decedent' (Specify only highes	s Education			dent's Usual Oc kind of work do		t of workin	10	16b. Kind of B	usiness/Ind	dustry
21	within iene.	npl	Elementary/Secondary (0-12)	College (life.	DO NOT use rel	rired)	OF WORKIN	, y			
2	filed withir Hygiene. other then sent, II.e M.		5 Years	1		Ho	memaker					Home:	
and	be fi	Be	17. Father's Name (First, Middle, L					18. Mothe			Maiden Surnan		
Ĕ	shoutd by	2	Blaine Page 19a. Informant's Name/Relationsh	-		40: 14:11					Marie R		
Maryland 21215-0036		1	Debra L. Menin		hter)						r, City or Town, Hall,		Code) 1161
	s 1 and 2 should if Health and Meritem 27 Is marke other traumatic		20a. Method of Disposition	- (20b. F	Place of Dispo	sition (Name of			ate T	20c. Location -		
Baltimore,	Pages nent of I int: If it		1 ☐Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State	•	natory or other p Nation.	· 1	/0/20	107			
Ħ	+ E 2 2 2 .		21. Signature of Funeral Service L	• • • • • • • • • • • • • • • • • • • •	Pici		. Name and Ad			-	Laure	I, Ma	ryland
m	Depa Impo		Quetin a	Da Dam		D 75	uda-Ruc	k Funei	ral H	Home of	Dundal Maryland	k, In 212	.C.
			23a Part1. Enter the disease, or o shock, or heart failure. List of	complications that controls one cause on e	aused the deat	h. Do not ent	er the mode of o	tying, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	()	cranic	ر ٥٥	syrue	tive '	Pul	mona	ry Du	0625	Onset and Death
	/Medical Examiner		resulting in death)		(or as a conseq						J		99.7
	Lammer	بيد	Sequentially list conditions,	b	description of the last								
	De V tie	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence oi):							
_,	and and	xar	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):							
8760,	ficate be executed physician and the burial-transit	dical E		d									
9	tificat ig phy as thi	ledi											
Вох	endin use	N/u	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Cotonio assass				23d. Dat	e of deliver	у
B	deat ed for	sicie	in the past 12 months? 1 — Yes 2 ANo		ant at time of d		Ectopic pregnar Other (specify)				Moi	nth I	Day Year
P.O.	that the death certific ed by the attending p detached for use as	Physician/Me	9 Unknown						_				
ŝ,	es pe	by	Part II. Other significant condition	is contributing to de	eath but not res			given in Part I.		1.7			e cause of death?
orc	v requir been si should	ted	Corscars	700	-	Dise	AJK.	CIT		1 X 1Y	es 2 No	3 Proba	ıbly 4 Unknown
Vital Records,	ne law has b ge 2 si	Completed	DCDLE 27	(sn	1-17	<u> </u>				24a. Was a autops	sy p	rior to com	sy findings available inpletion of cause of
alF										perform 1 Tes		eath?	2 No
Z.	ding Physician: Th. n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:)ther		(Check only on			
of		T. To	1 ☐ Yes 2 No 27. Manner of Leath	28a. Date		ER/Outpatient 28b. Time of	3 □ DOA 28c. In	4 L Nur			ence 6 Other)
O	nding f th. : After s funer	tlor	1 Natural 5 Pending 2 Accident investiga	(Mont	th, Day Year)	Injury	W	ork? □Yes 2□N		od. Describe in	ow injury occurr	50	
Division	I or Attendi after death Director: A I in by the fi	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place	of Injury - At ho	ome, farm, stre			-	3f. Location (SI	reet and Numbe	er or Rural	Route Number,
۵	tal or A	Certification:	4 Holflicide	Duildi	ng, etc. <i>(Specif</i>)	/)				City or Town	n, State)		
	Hospi 4 hour	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the ba	best of my kno	wledge, death	occurred at the	time, date and	f place, an	nd due to the ca	ause(s) and ma	nner as sta	ited.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Med	one) 29b. Signature and title of certifier	and manr	ner stated.			nse number					
)	Y N L S		Marke	15 11	201	2 MM	250. Lice		7		9d. Date signed		
	1/		30. Name and address of person w	to completed as:	n cel	3 (5) (5)	leiet)	12 (2	- (IANI.	0,6	
	Y \		M KTALEL	MCN &	1	4 9		3 tern	. 1	361tr-	-07e	M	21224
	Sta	te	31. Date filed (Month, Day, Year)	32.4	egistrar's Signa	ture		_			(•	
	Registr	ar	JAN 1 1	2007	Charles A	7. AM	de						

Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Legible.					
State of Maryland / Department of Health and Mental Hygiene						
Certificate of Death	Reg. No.					

		4	1- State Registrar Cer	rtificate of		, ,	ı. No.		
1	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3 Jime of Death	
	/Medic	al .	DONALD H. BAUMER, JR. 4a. Facility Name (If not institution, give street and number)	4h City Town 6	or Location of Death	JANUARY	7, 2007 4c. County of Dea		
	Examin	er	FREDERICK MEMORIAL HOSPITAL	FRED	ERICK		FREDERI	CK	
ĺ	Funeral Director	200	5. Social Security Number 6. Sex $1 \times M$ $2 \square F$ 7. Age (In yrs. last birthday) Usual Residence of Decedent	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) Jan. 3,	rear) Co	thplace (State or Foreign ountry) w York	
	yland Iow at		10a. State 10b. County 10c. City, Town or Loc	cation				10d. Inside City Limits	
	e Mar 3a-f st tified	ector	Maryland Frederick Mon	nrovia				1 ☐ Yes 2xx No	
	with th	Funeral Directo	10e. Street and Number	10f. Zip Code	7.0	100	g. Citizen of What Co		
	ns 23¢	eral	12101 Weller Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	2177 Was Decedent of H		cify Yes or No-	United		
2-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the X7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Married 12X Yes 2 □ No	If Yes, specity Cub 1 ☐ Yes 2ѬXNo	dispanic Origin? (Specian, Mexican, Puerto F	tićan, etc.)	Black, Whi	te, etc. hite	
היים	"natu	Be Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occup kind of work done	oation during most of working d)	g 16	6b. Kind of Business	/Industry	
7	within iene. than the Me	дшо	Elementary/Secondary (0-12) College (1-4or 5+) Sales		a)		Electroni	CS	
and	e filed al Hygi other vent, t	Š	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma			
ylar	ould b Menta arked atic e	To	Donald Haldeman Baumer, Sr.		Audrey Ma				
Ma	d 2 sh th and 7 is m traum		· · · · · · · · · · · · · · · · · · ·	-	and Number or Rural		*		
ย์	Healt Healt tem 2	- 4	Donald H. Baumer, III / Son 5519 20a. Method of Disposition 20b. Place of Dispos		ty Way NE,		c. Location - City or		
Dallimor	iit. Pages artment of ortant; If I Injury or		4 Donation 5 Other (Specify) Resthaven	n Cremato	ry 20	007 F	rederick,		
מ	Depa Impo any tr		KE ST	STHAVEI 501 CATO	N°FUNERAL OCTIN MTN	. SERVI I. Hwy.	CES, SKI EREDERIO	КОТ СОДУ РА СК, MD 2170]	
			23a. Part1. Int if the sease, or loom lications that caused the death. Do not ente shock, if heart failure. List by yone cause on each line.	er the mode of dyir	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)					Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):	1 T C					
	ed Mass	ē	Sequentially list conditions, cause. Enter Underlying Cause. Disease or injury Hypertension	I Infarct	tion				
A	cuted nd ransit	Examiner	that initiated events						
Ď,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):						
00/00,	icate t physic s the b	Medical	d						
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		⊒Ectopic pregnancy ∃ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year	
'n	ss that gned t	by P	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tobacco use contribute to the cause of death?			
cords,	requir een si rould I	ted	Hypercholesterolemia			1 🗆 Yes	2⊠No 3□P	robably 4 □Unknown	
ם ב	: The law cate has b	Completed				24a. Was an autopsy performe 1∐ Yes 2∑	ed? death?	utopsy findings available completion of cause of	
<u> </u>	slcian certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	oth Oth	26. Place of Death				
5	g Phy er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	N SKY DOA	4 ☐ Nursing Hom	e 5 ∐ Residene 3d. Describe how	ce 6 □Other (Spe injury occurred	cify)	
200	endin ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation		Yes 2 □ No				
2	ial or Atte s after de al Directu ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	28	Bf. Location (Stree City or Town,	et and Number or R State)	ural Route Number,	
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the tile vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cau d at the time, dat	se(s) and manner as e and place, and du	s stated. e to the cause(s)	
	Vor Com	Σ	29b. Signature and title of certifier M M M M M M M M M M M M M	29c. Licens	le 90	1/9	Date signed (Mont	h, Day, Year)	
*	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, I		7.1	' 1 1			
	Sta	te	Labkhand Kossari, M.D. 20407 Senec 31. Date filed (Month, Day, Year) 32. Registrar's Signature	a Meadow	s Pkwy., G	ermantov	vn, MD 208	3/6	
	Registr	_	JAN 1 1 2007 Believes 15 fre	de la					

07-00247 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Troy Lamont Chesley State of Maryland / Department of Health and Mental Hygiene 00424 1- For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month January 9, 2007 Medical Examiner Troy Chesley Sr. Lamont 0157 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Sinai Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Foreign 29 Country) 217-11-7284 34 11 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. Baltimore 1 X Yes 2 No NA death with the Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3200 Dorithan Road 21215 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces? Never Married White, etc. Yes within 72 hours after 3 X Widowed Black Examiner 4 Divorced If Yes, Give Year Yes 2 X No specify Specify ≥ 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore Police Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical Baltimore, MD 21215-0036 12th grade 2yrs Police Officer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Chesley Joyce Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Kent Chesley-Mother 3200 Dorithan Road, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 1/16/07 Dulaney, Donation 5 Other Specify 21 Signature of Funeral Service Licenses 2. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 art I. Enter the disease, or complication **Physician** tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and by Physician/Medical attending physician or use as the burial signed by the ar Completed

Division of Vital Records, P.O. Box 68760,

After within 24 hours are.

To the Funeral Dir

Be

Certification: To

Medical

State Registrar

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

UNPENDED	AMENDED				
FEMALE: b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unkr	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of	2 Fetal deat		nancy	23d. Date of delivery Month Day Year
art II. Other significant condition	ons contributing to death but not	resulting in the underlyi	ng cause given in Part I.		
Was case referred to medical examiner?1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatient 3	26.Place of Death (Chec		esidence 6 Other
7. Manner of Death Natural 5 Pendi 2. Accident Invest	28a. Date of Injury (Month Day,Year) Jan 9, 2007	28b. Time of Injury 0100 hrs	28c. Injury at Work?	28d. Describe how Subject shot	w injury occurred
Suicide 6 Could determ	not be nined 28e. Place of Injury - At (Specify) Street	home, farm, street, facto	ry, office building, etc.	or Town, State	eet and Number or Rural Route Number City e) ad, Baltimore, Md.
ne) 2 Medical Exam	ysician: To the best of my knowle niner:On the basis of examination and manner stated				
b Signature and title of certifier		2	9c. License number	2	9d Date signed (Month Day Voor)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 9, 2007

20

a.m.

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JAN.7,2007 2:30A CLARK CORA MAE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE STELLA MARIS-DULANEY TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 83 219 30 1558 Director MAR. 23.1923 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1√Yes 2□No Director MD. N/ABALTIMORE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21216 3030 GWYNNS FALLS PKWY USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MEMORIAL STADIUM Elementary/Secondary (0-12) College (1-4or 5+) 9TH HOUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT STONE LEE ONORA HATCHER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE HURT/daughter GWYNNS FALLS PKWY BALTO MD. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition GREENMOUNT CREMATORY 1AN.10,2007 BALTO, MD. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) nature of Funeral Service Licensee 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Dunadine PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): physician use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \bold Other (Specify) HOSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 1 1 2007 Registrar DHMH 17 Rev 1/2001

			1 _ State	tate of Maryland / Depa	artment of Health and N		71111	00426
No.	7 35 e	*	Registrar Decedent's Name (First, Middle, Last)	007	uncate of Death	Reg. 2. Date of Death		3. Time of Death
\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Physici /Medi		Birdie Covina		,	JANUARY (Day Year 5 , 2007	9:00p M
	Examir	ier	4a. Facility Name (If not institution, give stre	1 1	4b. City, Town, or Location of Death		4c. County of Death	
16	Funeral		5. Social Security Number 6. Sex	URSING HOME FABRE	BAH MORE N If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
a a	Director		217.24.6A77 10M	2AF 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		ary land
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryl f sho	tor	mp	Q a	timore			1 Yes 2 No
	n the or 28a e notii	Director	10e. Street and Number	- Cac	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath will		1665 W. North A	venue	21217		USA	
	ter de Items ner m	Funeral		Was Decedent Ever in U.S. Armed Forces? 1 1 ☐ Yes 2 ☑No	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notitied at	ρ		If Yes, Give Year or Dates:	I□Yes 2014-No Specify:		Specify: B1	ack
21215-0036	d within 72 hours after death with the Marylar giene. If than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. Deced	dent's Usual Occupation kind of work done during most of work	ina 16b.	. Kind of Business/In	CA
121	within iene. than "	mp		College (1-4or 5+)	kind of work done during most of work	9	7	
	Hy Hy othe ent,	Be Co	17. Father's Name (First, Middle, Last)	year	18. Mother's Name	e (First, Middle, Maid	Domest() len Surname)	7
/lan	9 6 5 p	To B	Dave Booze		Bertha	a Johns	m	
Maryland	2 sho n and l is ma rauma		19a. Informant's Name/Relationship (Type.	Print) 19b. Mailin	g Address (Street and Number or Run			Code)
- 10	ges 1 and 2 should it of Health and Mei If item 27 is marki or other traumatic		14rone L. Crowner 20a. Method of Disposition	20b. Place of Dispos	SunhillVillage Cr.		inder Mill,	
Baltimore	Pages nent of nt: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	val from State cemetery, cren	natory or other place)	i	Location - City or To	
altir	그 두 말 루		21. Signature of Funeral Service Licensee	LOUGOT 1 9	Park Cometry 01:1	2.200+ 12	altimore	mi) Sexue
ä	Depa Impo any Ir		Vaughn C. Ase	eme 8		Pronde		
			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Progressive	Dehne			Onset and Death
	Examiner			Due to (or as sonsequence of):				
		ner	Sequentially list conditions, if any learning by the cause. Enter Underlying	Directo (or as a consequence of):	recey			
	ecuter and -transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dementie				
8760,	ficate be executed physician and s the burial-transit	ical E		Due to (or as a consequence of):				
687	tificate ig phys as the	ledic	d	ighter en er	7			
Box 6	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med		f yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of delive	
P.O.	he dez the al	ysici	1 Vec 2 No		Other (specify)		Month	Day Year
σ,	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions contrib	rting to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ords	w require: been sig should be	ed by				1 ☐ Yes	2 No 3 Prob	ably 4 Tonknown
ecc	e law re has be je 2 sho	Completed				24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
a E	ician: The certificate ha ector, page					performed? 1☐ Yes 2☑1	death?	2 □ No
₹	ysiciar is certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 TO NO Hosp	ital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	011	(Check only one)		
יסר	Attending Physician: r death. sctor: After this certifically the funeral director,	-1	27. Manner of Death 2	8a. Date of Injury (Month, Day Year) 28b. Time of Injury		me 5 Residence 28d. Describe how in		/)
Siol	tendir eath. tor: Af the fur	catio	1		M 1 ☐ Yes 2 ☐ No			
Division or Vital Records,	or At after d Direc in by	Certification:	4 Homicide determined 2	Be. Place of injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physicia	n: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as st	ated.
	the Ho iin 24 I the Fu	Medical	(Check only 2 Medical Examiner:	On the basis of examination and/or invand manner stated.	restigation, in my opinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
	vit To	2	29b. Signature and title of certifier	Mp	29c. License number D 3(464		Date signed (Month, I	Day, Year)
	10		30. Name and address of person who compli	ated cause of death (Item 23a) (Type F	Print\			
	1		SHOA(13 A. HAS H M	I (MD, 2 (1 , 1	FUTAN ST Shite 3	08, BAC	TIMORE	mp 2,201
	Sta		31. Date filed (Month, Day, Year)	3. Registrar's Signature	AL a	1 -		
	Registr	ar	JAN 1 1 2007	Bleve & Again				

		State of Maryland		artment of H			2111	17 00427
8		Registrar 1. Decedent's Name (First, Middle, Last)	Oei	tineate of t	Jean	2. Date of Death	g. Né U U	3. Time of Death
Physici /Medi		EUGENE DAVID CORBO				Month JANUARY	Day	Year 207 12:00F M
Examir		4a. Facility Name (If not institution, give street and number)		4b. Cîty, Town, or			4c. County	
		Saint Joseph Medical Cente		If Under 1 Year	Tows of		88	altimore
Funeral Director		5. Social Security Number $ 6. \text{ Sex} 125-14-8123 $ 6. Sex $ 1 \times \text{M} 2 \text$	Yrs.	Months Days	Hours Min.	(Month, Day,		9. Birthplace (State or Foreign Country) New York
7		Usual Residence of Decedent				pury 21,	1/2/	
larylar show ed at	5	10a. State 10b. County 10c. City,						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
the M 28a-f notifie	Directo	Maryland Baltimore Times. Street and Number	moniu	10f. Zip Code		10	g. Citizen of W	
3a or st be	Ö	305 Lochview Terrace			.093			S.A.
ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race	- American Indian, , White, etc.
s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 1 ☐ Yes 2 ☐ No		I∐Yes 2 X ∏No	Specify:	o modifi, oto.)	Specify:	
thour sales	ed b	1945-4	16a. Deced	lent's Usual Occupa	ation	11		White siness/Industry
Frin 72 an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	luring most of wor)	rking		and do and do and do and do and do and do and do and do and do and do and do and do and do and do and do and do
ed with ygien t, the	Con	4 years	Ac	counting	Clerk			ional Facility
Id I Jidild ZIZIS-DUSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M		<i>;)</i>
should should mark matic	ရ	Joseph Corbo 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	Edith	Iral Route Number,	ZZO	State Zin Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed within 72 hours after death with the Marylan ti of Health and Mental Hygene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Joseph Corbo (son)		ochview '				and 21093
Pages 1 and the pages 1 and th		20a. Method of Disposition 20b. Placticer 20b. Placticer 1	e of Dispos netery, cren	sition (Name of natory or other place				City or Town, State
Pages tment of tant: If It		4 Donation 5 Other (Specify) Saint	s Peter	r & Paul Ce	m. 1-	15-07 E	lmira,	New York
permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee	22 N	. Name and Addres 11tche11-1	s of Facility Viedefel	d Funeral Baltimore	Home,	Inc.
		23a. Part1. Enter the disease, or comb lications that caused the death.	Do not ente	6500 Yorl	Road	Baltimore	, Marýl	Land 21212 Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		,,,,,	,	and the second second	,	Interval Between Onset and Death
/Medical		disease or condition resulting in death) a. SEPSIS Due to (or as a consequer	nce of):					
Examiner		Sequentially list conditions, b. FERFORATED		M				
led sit	nine	cause. Enter Underlying Cause (Disease or injury	ice of):					
be executed sician and burlal-transit	Examin	that initiated events c. Due to (or as a consequer	nce of):					
ate be hysicial the buri		d						
entifica ing ph	Med	IF FEMALE:						
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	eath 3	Ectopic pregnancy			23d. Date Mon	of delivery th Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown	n b⊔	Other (specify)				
ires that the designed by the a	by Pt	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contril	bute to the cause of death?
w require been sig						1 ☐ Yes	2 No 3	3 ☐ Probably 4 ☐ Unknown
law r las be 2 sh	Completed					24a. Was an autopsy	l pr	ere autopsy findings available for to completion of cause of
						performe 1 Yes 2	d2 de X No 1[eath? □Yes 2D7No
siciar certifi	o Be	25. Was case referred to medical examiner? 1 Yes 20 No Hospital: 1 Yinpatient 2 ER	(Outnotiont	2000 Othe	r: 3	th (Check only one)		
g Phy er this eral d		27. Manner of Death 28a. Date of Injury 28	Outpatient	3 DOA Office 28c. Injury Work	4 LI Nursing H	ome 5 ☐ Residen 28d. Describe how		<u> </u>
ending lath. or: After he funer	atio	2 Accident investigation	Injury		r ′es 2□No			
or Att fter de Direct in by t	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number State)	r or Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death	occurred at the tim	e, date and place	and due to the car	se(s) and man	unor as stated
the Hos nin 24 h the Fur npletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my op	pinion, death occu	rred at the time, dat	e and place, ar	nd due to the cause(s)
To th Within	Me	29b. Signature and title of certifier		29c. License	number	290	d. Date signed	(Month, Day, Year)
14		- (milly for 11/1)		D24Ø	34		11811) [
51		30. Name and address of person who completed cause of death (item 23		,			1	
Sta	te	TIMOTHY IOW M.D. 76-01 OSL 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ER D	RIVE TO	WSON, MA	ARYLAND_	21204	
Registr		JAN 1 1 2007 Lane &	A SA	MI				

		1_3	For State Registrar		Stat	e of M	arylan		artment of I		d Mental H	ygienę Reg. No	7 11 11 .	7 0	0428
Phys		1. De		e (First, Middle		EY					2. Date of D	eath	, 2007		Time of Death 8:05 a ^M
	edica mine	4a. Fa			, give street an				4b. City, Town,	or Location of De		4c.	County of De	ath	
Funer Direct			cial Security N		6. Sex		e (In yrs. I	last birthday)	If Under 1 Year Months Days		Irs. 8. Date of B (Month, D	irth Day, Year)	9. B	irthplace Country)	(State or Foreign
tryland thow		10a. S	Residence o	10b. County			10c. City	y, Town or Lo	cation		- 23(1)/151) 10/11		10d. Ir	nside City Limits
th the Ma or 28a-f s e notifies		10e. S	Street and Nu		e Georg	e's	L	aurel	10f. Zip Code			10g. Citi	zen of What (TYes 2 No
eath wi	1	20		Stree		Događant	Ever in U.	C 123	2070		(Cassify Van and	L	S.A.	ariaan In	dian
urs after dal', or item		3		ied 2□ Marr 4□ Divorced	ed 1XX			٠	f Yes, specify Cub		(Specify Yes or N verto Rican, etc.)	0-	Black, Wh		,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	Total and	Ele	(Spec mentary/Second	ndary (0-12)	t grade comple	ted) ge (1-4or !	5+)	(Give life. L	lent's Usual Occu kind of work done OO NOT use retire	during most of v	working		nd of Busines		′
filed w Hygie other the	000			(First, Middle,	Last)			Carp	enter	18. Mother's N	lame (First, Middle		nstruc [.] Surname)	tion	
y carry	G C		oward I	ee Cha	ney					Martha	a Serena	Smit	h		
d 2 sho th and 7 Is m				ame/Relationsl	nip (Type. Print) cousi	n	1			Rural Route Num				
is 1 and 1 feel filter 2		20a. N	Method of Disp	oosition					sition (Name of natory or other pla		ad Chest		cation - City of		21619 State
Pages 1 ment of Hi ant: If Iten				\square Cremation 5 \square Other (S)	3 □Removal pecify)	rom State				1	/16/2007	Cro	wnsvil	le, M	Maryland
permit. Departi	опсе.	21. S	signature of Fu	ineral Service	icensee	/ M	100773)			l Home, F le Laure		1	7 00	207
		23a.	Part1. Enter t shock, or hea	he disease, or	complications to	hat caused on each li	I the death				liac or respiratory		aryıand	App) 7 0 7 roximate rval Between
Physicia /Medic	-	disea	ediate Cause (ase or condition ting in death)	Final n	-		Cance							Ons	et and Death
Examin	200				Du .	e to (or as	a consequ	uence of):							
pe d	i i	Sequ if any cause	entially list co , leading to in e. Enter Unde	nditions, nmediate rlying	Du Du	e to (or as	a consequ	uence of):							
be executed sician and the burial-transit	Fyaming	that in result	e (Disease of nitiated events ting in death) I	ast	c	e to (or as	a consequ	uence of):							
the bur	100	3			d									-	
The law requires that the death certificate be executed to has been signed by the attending physician and apage 2 should be detached for use as the burial-transit	Dhveician/Mo	IF FE 23b.	MALE: Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ☐ No	1 □ L 4 □ F	ive birth	pf pregna 2 □ Fetal time of de	death 3	Ectopic pregnanc Other (specify)	гу		2	23d. Date of d	elivery Day	Year
res that t signed by be detact	70		. Other signi	icant conditio	ns contributing	to death b	ut not resu	ılting in the ur	iderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute	to the cau	use of death?
w require been signature	to de										_ 1 X	Xes 2[□ No 3 □ F	Probably	4 □Unknown
	Completed										24a. Was – auto perf 1∐ Yes		24b. Were a prior to death?	completi	ndings available ion of cause of No
ysicial is certii directo	A G) ex	ras case refer kaminer? □ Yes ②	red to medical No	Hospital:	1 🔲 Inpatie	ent 2 🗆 E	ER/Outpatien	t 3 DOA Oth		Death <i>(Check only</i> Home 5 \square Res		—————————————————————————————————————	ecifu)	regiver's
ing l	2		anner of Deat	5 Pending	, (Date of Inju Month, Da	ry y Year)	28b. Time of Injury	Wo	ry at rk?	28d. Describe			Re	sidence
l or Attencafter death Director:	Cartification	3 4	☐ Accident ☐ Suicide ☐ Homicide	investig 6	ot be 28e. F	Place of injuding, et	ury - At hor c. <i>(Sp</i> ec <i>ify</i>	me, farm, stre	M 1 = 1 = eet, factory, office]Yes 2∏No ———	28f. Location City or To	(Street and own, State)	d Number or F	Rural Rou	te Number,
To the Hospital or Attend within 24 hours after death. To the Funeral Director; / completely filled in by the f	Modical C		Certifier (Check only one)	1 ☐ CertifyIn 2 ☐ Medical I	Examiner: On t	the best he basis o manner sta	f examinat	wledge, death tion and/or inv	occurred at the tivestigation, in my	ime, date and pla opinion, death of	ace, and due to the	cause(s) , date and	and manner a place, and do	as stated. ue to the o	cause(s)
To the within To the comp	Me	29b. \$	Signature and	tiple of challing					29c. Licens				e signed (Moi		,
1 1		00.11		Xe	net			00-1/7		53277		Jar 	nuary 1	.1, 2	007
6T1		Dr	. Stin	gle 75	7	enway	Cent	er Dri		te T-4,	Greenbel	t, Ma	ryland	l 20	770
	State istrar			th, Day, Year) N 1 1 2	007	32. Registr	ar's Signat	ture							

07-00165 Elsie Charlton

isle Chariton		State of Maryland / Department of Health and Mental H	Hygiene	200	7 001.2
Physici	an/	1- For State Registrar 1. Decedent's Name (First, Middle Last)	2. Date of Dea	Reg No 200	1 0042
Medical Exam			Month January 6	Day Year	3 Time of Death 1755 hrs
- Comment		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Death	
		University Hospital Baltimore			
.Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24H Months Days Hours M		irth(MM/DD/YYYY) 9. Birt Foreig	
Director		215-24-7962 1 M 2XF T Yrs.	12/30		untry) MD
any		Usual Residence of Decedent 10a State			10d. Inside City Limits
3	_	112			1 Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number, 10f. Zip Code		10g. Citizen of What Coun	
with the Maryland ns 23a or 28a-f sho	Dire	3325 Elbert Street 21229	ľ	115A	•
3 %	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (can Indian, Black,
r death or ite must	Fun	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	White, etc	
hours after death natural", or iten Examiner must b	þ	3 Widowed 4 Divorced If Yes, Give Year or Detection (Specify only highest grade completed) 16a Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of		Specify 5	ack
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/Ir	adustry L.S
336 thin 72 re than	nple	Ivear Clerk		Dict of	2.00
15-0036 filed within 72 Il Hygiene ed other than '	S	17. Father's Name (First, Middle Last) 18.Mother's Name	ne (First, Middle,	Maiden Surname	11
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be	Steven Young, Sr, Eva	Mae	De-Shie	lds
O g B is it	ပို	19a, Informant's Name/Relationship (Type, PT) 19b. Mailing Address (Street and Number or	Rural Route Nur	A 1	Zip Code)
re, MD s t and 2 sh of Health and If item 27 is		Cornelius D. Charlton Son 690 Kent Jown D 20a Method of Disposition (Name of cemetery,	Date Date	tsuille, M	1D 20785
		1 Dunal 2 Cremation 3 Removal from State crematory or other place)		<u> </u>	
Iltimo nit Page artment ortant:		4 Donation 5 Other Specify GreenMount 1/1 21. Signature of Fugeral Service Licentee 22. No an Address of Facility	6/2007	Baltimore	e, MD
Balti permit Departr Import		21. Signifiure of Fugeral Service Licentee 22. Vaughor Service Licentee 33. Bottleford 5151 Baltimore N	bt'l Pik	6 Rollo M	D 21229
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arr	est, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Head injuries with complications			Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):			
	Examin	Common Enter Underlying Course (Disease or injury that initiated			
ecuted and transit		events resulting in death) Last Due to (or as a consequence of): d			
	Medical		/16 /07		
60, cate be events by the solution of the solu	Med	IX UNPENDED X AMENDED, per FH, 23a,27,28a-f, perME, g865, 3 IF FEMALE: 23c. If yes, outcome of pregnancy	/16/0/ 11	23d Date of delivery	
x 687 h certific tending p	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month Da	ay Year
Box 687 e death certific the attending p	ysic	1 Yes 2 ✓ No 9 Unknown 9 Unknown 9 Unknown			
that the deatl	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did to	bacco use contribute to the	ne cause of death?
, P.O. ires that the signed by	d by		1 Yes	2 No 3 Proba	ibly 4 🗸 Unknown
ords, w requir	Completed		24a Was autop		ppsy findings available
teco	E O			rmed? death?	mpletion of cause of
ital Reiciau; The scertificate	au i	25. Was case referred to medical 26. Place of Death (Check		2 10 10 105	2
of Vital Records, g Physician: The law requir wher this certificate has been si neral director, page 2 should t	To B			Residence 6 Other	
n of ding Pb After 1 funeral		27. Manner of Death 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury 28c, Injury at Work?	I	now injury occurred	
Sior Attend death death by the	äţi	2 X Accident Investigation 1/2/2007 unk	fell dow	vn steps	
Division Division pital or Attendit ours after death, teral Director: A	Certification:	Suicide 6 Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined	28f. Location (S	Street and Number or Rura tate) Ert St. Baltimo	Route Number, City
Hospid 4 houn		29a Certifier			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date	e(s) and manner as stated and place, and due to the	cause(s)
E 3 E 8	Me	and manner stated. 29b. Signature and title of certifier 29c License number		29d Date signed (Monti	h, Day, Year)
		Patrillania Tollah s O.C.M.E.		January 9, 2007	
		30. Name and address of person who completed cause of death (Item 23a)		L	
Ф		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimol	re, MD 21201	1	
St Regist		31. Date filed (Month, Day, Year) JAN 1 1 2007 32 registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00430 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Daniel Brook 9. 2007 3:30 A Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise of Columbia Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□F Director 579-03-0219 91 Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle or than "natural", or items 23a or 28a-f ehor 1 ☐ Yes 2 No Directo Delaware Sussex Selbyville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19975 Murphy Circle, W 38262 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 以Yes 2□No 1941—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🎇 No Specify: þ White 3 X Widowed 4 □ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engine Mechanic Foreman Andrews Air Force Base 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Melvin Carter ဂ္ Loula Yeatman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any Injury or other trau once. Connie L. Duvall - Daughter 13000 Twelve Hills Road, Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 1/11/2007 Brentwood, Maryland 21. Signature of Foreral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 2078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimers Dementia 5 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s 2 \(\text{No} 1 Yes 2 X No 1 Tyes To the Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Living 1 ☐ Yes 2 📉 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

6

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 1 2007

Harry Li, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10780 Hickory Ridge Road, Columbia, Maryland 21044

2007 32. Registrar's Signature

m.D.

D56531

January 9, 2007

07-00141		Please Type or F							ible.	
Christene A. Cal		- For State Of	Maryland /		ment of F ficate of E		id Mental F	tygiene	200	7 0043
Dharinia	F	Registrar 1. Decedent's Name (First, Middle,Last)		Certii	icale of L			Reg 2. Date of Death	No E O	3. Time of Death
Physicia Medical Examin								Month January 5,	Day Year 2007	2305 hrs
		CHRISTENE A. CALVERT 4a Facility Name (if not institution, give stre	eet and number)		4b.	City, Town, o	r Location of Deal		4c County of Death	
		East bound I-70 East of route	27		1	√lount Airy			Carroll	
Funeral		5 Social Security Number 6. Sex	7. Age	(In yrs. last		If Under 1 Yea			(MM/DD/YYYY) 9 Birtl Foreign	hplace (State or
Director		199.52.9258	2 X F	46	Yrs.	Months Day	ys Hours Wi	JULY 16,	Col	
>		Usual Residence of Decedent		ine Chi Te	own or Location					10d Inside City Limits
w an		10a. State 10b. County		roc. City, TC	WITOI LOCATION					1 Yes 2 No
yland 1-f sho	흱	PA BEAVER 10e. Street and Number		BEA	VER FALLS	Of, Zip Code		100	g. Citizen of What Coun	trv?
e Mai or 28	įį									
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	805 9th AVE 11. Marital Status 12	. Was Decedent E	ver in U.S	13. Was [15010 Decedent of H	ispanic Origin? (\$	Specify Yes or No-	USA 14. Race - Americ	can Indian, Black,
leath v	nue	1 X Never Married 2 Married	Armed Forces? Yes 2	No	If Yes	specify Cuba	an, Mexican, Puerl	o Rican, etc.)	White, etc	
after o	by F	3 Widowed 4 Divorced If Your Graf	es, Give Year Dates.		1 Y	es 2 X N	o specify:		Specify Wi	HITE
nours :	pa .	15 Decedent's Education (Specify only h	ighest grade com				ation (Give kind of e DO NOT use re		16b. Kind of Business/Ir	ndustry
36 n 72 } nan "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)				ŕ		
withi withi giene her th	E .	12 17. Father's Name (First, Middle, Last)		į		PRN	18.Mother's Nan	ne (First, Middle, M	HEALT aiden Surname)	Н
21215-0036 uld be filed within 7 Mental Hygiene marked other thau	Be C							LEY BELL	,	
212 buld bould bound bou		CHARLES CALVERT 19a. Informant's Name/Relationship (Type,	Print)		19b. Mailing A	ddress (Stre			per, City or Town, State,	Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If riem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	. [PATTERSON CLARK			805 9t	h AVE BE	AVER FALLS	S, PA. 1050		
re, land land land land land land land land		20a. Method of Disposition 1 Burial 2 X Cremation 3 X I	Removal from Sta		ace of Disposition matory or other		emetery,	Date	20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Flee Important: If ites		4 Donation 5 Other Specify:	itemoval nom ota		SBURCH C	REMATION	1 1.º	11.2007	PITTSBURGH,	PA
trinit rmit rports ports jury e	1	21. Service Lern	1 0		22. Nar F I NK	ne and Addres	ss of Facility HOME, P.	۸.		
		K. GREGORY FINK MO11			426_	CRAIN HW	YY SW GLEN	BURNIE, MD		I O a manufactura de la transporta
Physician /Medical	1	23a Part I. Enter the disease, it somplicates allure. List only one cause on each I	ine.	ine death. D	o not enter the	mode or dying	y, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner			to (or as a conse	guanca of):						Death
		b	to (or as a corise	querice or).						
	je l		to (or as a conse	quence of):						
	Examiner	cause. Enter Underlying Cause (Liceace of injury that milliand events resulting in death) Last	to (or as a conse	quence of):						
executed an and al - transit		d.	,	,						
8 8 8	Jica	UNPENDED	MENDED							
Box 68760, death certificate be the attending physicited for use as the buried for use a	sician/Medical		23c. If yes, outcom	e of pregna	incy				23d. Date of delivery	
687 certifi	ian	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at	time of deat	h =	dodin	Ectopic preg	nancy	Month D	Day Year
SOX death e attel	ysic	1 Yes 2 No 9 V Unknown	9 Unknown		5 Othe	r (Specify)			1	
i, P.O. Boires that the designed by the	, Phy	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the un	derlying cause	given in Part I.	23e Did tob	pacco use contribute to	the cause of death?
, P.O. res that th signed by be detach	d by							1 Yes	2 No 3 Prob	pably 4 Unknown
tal Records, cian: The law requir certificate has been s	Completed							24a Was a autops		topsy findings available completion of cause of
eco he law ite has	g mc							perforr 1 ✓ Yes 2	ned? death?	
tal Recient The sector, page	Be C	25. Was case referred to medical				26 Pla	ce of Death (Chec	ck only one)		
Vita nysicia this ce direc	0	examiner? 1 ✓ Yes 2 No	oital. 1 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other Nur	sing Home 5 F	Residence 6 🗸 Other	Scene
Division of Vital Records, tal or Attending Physician: The law requirents and after clean. After this certificate has been steed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second the	n:	27 Manner of Death	28a Date of Inju (Month, Day Y	ry 2 ear) ,	28b. Time of Inji 2257 hrs	ury 28c. In	jury at Work?		ow injury occurred ixed object collision	ın
ion ttend death ctor: y the f	Certification:	1 Natural 5 Pending 2 ✓ Accident Investigation		-		1_	Yes 2 V No			
Division pital or Attent ours after death neral Director: filled in by the	ţį	3 Suicide 6 Could not be determined	28e. Place of Inj	•		factory, office	e building, etc	or Town, St		
D spita hours ineral		4 Homicide	(Specify) Inte		·			-	0 East of route 27, N	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	ical								e(s) and manner as state and place, and due to th	
To T Com	Medical		d manner stated.				nse number		29d Date signed (Mod	
		his his m	5)			0.0	C.M.E.		January 6, 2007	
•	- 12	30 Name and address of person who com	pleted cause of d	eath (Item 2	·3a)					
Q		Ling Li, MD Assistant Med				Baltimore	e, MD 21201			
	tate	31 Date filed (Month, Day, Year)	32. Registra	100	he.	80				
Regis	trar	JAN 1 1 200	J. Marie 14	made adjo	S. C. C.					

		1	For State Registrar	State of Ma			Health and	Mental Hygi	g. No. 00/	00432
	hysicia		Decedent's Name (First, Middle, La	st)		1		2. Date of Death Month	Day Year	3. Time of Death
_	/Medic	al -	WILLIAM		COLBU			JANUARY	5 200	·
E	Examin	er	4a. Fecility Name (If not institution, giv			4b. City, Town, o	or Location of Deat	h	4c. County of De	ath timore Co.
			7606 Belmont Av 5. Social Security Number 6. S		(In yrs. last birthday,		stview If Under 24 Hrs	8. Date of Birth	9.8	
	ineral rector			194 2□F 94	Vra	Months Days	Hours Min.	(Month, Day,		irthplace (State or Foreign Country)
			Usual Residence of Decedent					March 8,	1912 Ma	aryland
ırylan	Tet a	. 1	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2X No
e Ma	8e-f s	- A		ltimore				Eastview		
vith th	al', or Items 23e or 28e-f show Examment must be notified at	Die	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
aath v	s 23e	-a	7606 Belmont	AVe.	vor in II C 12		21224	Consider Vos or No.	United St	cates
ter de	Hem Tar	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	701111 0.3.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
036 urs af	P. O.	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036 ad within 72 hours after death with the Maryland igiene.	"natural", Idical Exa	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	pation	rking 1	6b. Kind of Busines	s/Industry
24 fig. 7.	an "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+) life.	kind of work done DO NOT use retire	d)	ining		
d 21 filed wi Hygien	t. De	Co	11 Years			Steelwork			Steel In	dustry
yland 212 buld be filed with Mental Hygiene.	even	Be	17. Father's Name (First, Middle, Last					me (First, Middle, M	,	
aryla should I	narke	2	William A. Co		10h Maili	in a Address / Street		Ellen Cur		Zin Codo)
Maryland and 2 should be file the and Mental Hy	7 is n treun		Mr. William A. Co			rimary C		urai Route Number, 3B Fore	-	
Te, M	item 27 is marked other then "natur other treumetic event, the Madical	-	20a. Method of Disposition		20b. Place of Disp	osition (Name of			0c. Location - City of	
Baltimore, permit. Pages 1 at Department of Hea	= 5		1 Note: 1 Section 1 Secti		Oak Lawn	Cometervia		2007 B	altimore	Maryland
Baltir permit. P	ortent: njury	-	21. Signature of Funeral Service Lice		2	2 Name and Addre	ass of Facility			
B F G	any once		16106		1	Duda-Ruck /922 Wis	Funeral e ave. 1	Home of Dundalk, I	Dundalk Maryland	Inc. 21222
25			23a art 1. Enter the dis are, or com shock, or heart fail . List only	plications that caused t					1/1-1/1-1	Approximate Interval Between
Phys	sician		Immediate Cause (Final	DEBILLT						Onset and Death
/Me	edical		disease or condition resulting in death)		consequence of);					1 1000 (+)
Exa	miner		Sequentially list conditions	, CEREBRO	NASCULM	1 ACCIDE	ENTS			10 YEARS
/g = =	=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
hr ago	and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to force o	consequence of);					
760, te be executed	sician and burial-transit	E E		Due to (or as a	consequence or).					
9	the	dical		d						
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certifica is death.	attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy			•	23d. Date of d	elivery
Box leath cert	atter I for L	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at ti		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y		Month	Day Year
0 1	by the a	hysi	9 Unknown	9□ Unknown						
S, P	gned be det	by P	Part II. Other significant conditions	contributing to death but	not resulting in the t	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rd.	(7) T3	ed t	CHRONIC RENTL	FAILURE	HYPOTHYP	Meldias		1 □ Yes	s 2DXNo 3□1	Probably 4 Unknown
aw re	has been je 2 shoult	Completed		·				24a. Was an autopsy		autopsy findings available ocompletion of cause of
T ed	ate ha	E O						perform	ed? death?	
ita ien:	is certificate hadirector, page	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	
of Vital Records, Physicien: The law requires t	this or	ို	1 ☐ Yes 2 No		t 2 ☐ ER/Outpatie	nt 3 DOA	her: 4 Nursing I	-	nce 6 Other (Sp	ecify)
no no no no no no no no no no no no no n	fter	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo		28d. Describe how	w injury occurred	
Division I or Attending after death.	the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be		At home form of		Yes 2 □ No	28f. Location (Str	ant and Number or i	Rural Route Number,
Divi or A	Direc in by	ertif	4 Homicide determined	building, etc.	y - At home, farm, st (Specify)	төөт, тастогу, оптсө		City or Town,		nurai noule ivuiriber,
Div To the Hospital or within 24 hours afte	To the Funerel Director: completely filled in by the	a C	29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge, dea	th occurred at the ti	ime, date and place	, and due to the car	use(s) and manner	as stated.
the Ho	he Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of e and manner state	ed.					
Tot	COM	Σ	29b. Signature and title of certifier	1/	/	29c. Licens		29	d. Date signed (Mor	nth. Day, Year)
	\cap		James	Hand	~ MD	D	62032		ANUARY !	2007
	1			completed cause of de			- 1 0			
			31. Date filed (Month, Day, Year)	ASH SSO 32 Registrar	's Signature	12 BAYVI	EN CIRC	CLE BAL	LIMORE	MD 21224
	Sta Registr		JAN 1 1 2	007	J. D. A.	2044)				

			For State Registrar	State	of Marylan		artment of Hertificate of E		nd Mental Hy	giene Reg. No2 () ()	7 00433
	L		Decedent's Name (First, Middle	, Last)		-			2. Date of De Month	ath Day Ye	3. Time of Death
	Physici: /Medic		GUILIUS	DONALD	D'AMBROG	I			January	7, 2007	5:15A M
-	Examin	_	4a. Facility Name (If not institution,	give street and I	number)		4b. City, Town, or			4c. County of I	
			Broadmead	0.0	7 Ann //n um /	a a t histosia ()	Cockeys	V111e			Bidbolege (State or Foreign
	Funeral Director		5. Social Security Number 579-09-5462	6. Sex 1 √ M 2□ F	7. Age (In yrs. I	Yrs.	Months Days	Hours	Min. (Month, Da	9. 28,1913	Birthplece (State or Foreign Country) Italy
			Usual Residence of Decedent		30				Trat off E		*
	ryland		10a. State 10b. County			r, Town or Lo					10d. Inside City Limits 1 🗒 Yes 🔀 🐪
	8a-f	cto	Maryland Balti	more	Cocl	keysvi			<u>_</u>		
	with th	Die	10e. Street and Number 13801 York Road				10f. Zip Code	030		10g. Citizen of Wha	it Country?
	72 hours after death with the Maryland natural; or items 23a or 28a-f ahow disal Ezand or must be notified at	Funeral Director	11. Marital Status	12. Was D	ecedent Ever in U.	S. 13.			in? (Specify Yes or No		American Indian,
10	r iten	Fu	1 Never Married 2 Marri	ed 1 ☐ Ye	Forces? s 2/10/No				gin? (Specify Yes or No , Puerto Rican, etc.)		White, etc.
93	raf', o		3 X Widowed 4 □ Divorced	If Yes. Year o	Give r Dates:		1 ☐ Yes XX No	Specify:		Specify:	White
21215-0036	I within 72 hours after death with the Marylan liene. I then "naturel", or Items 23a or 28a-f ahow I'le Medicel Examinational De notified at	Completed by	15. Decedent (Specify only highes	's Education t grade complete	d)	(Give	dent's Usual Occupa kind of work done d	lurina most	of working	16b. Kind of Busin	ess/Industry
121	within lene.	Jd III	Elementary/Secondary (0-12)	College 5+	e (1-4or 5+)		DO NOT use retired)		Drug	State of	Maryland
d 2	be filed withir trail Hygiene. d other than event, I.e.M.		17. Father's Name (First, Middle,			Direc	tol of ro		r's Name (First, Middle,		nar y zana
Maryland	d ta b e	To Be	Attilio D'Ambro					Mich	elina Porc	:u	
ary		-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street a	nd Numbe	r or Rural Route Number	er, City or Town, Sta	ite, Zip Code)
	12 mg		Donald J D'Ambr	ogi Jr	Son			Road	Baltimore,		
ore			20a. Method of Disposition XX Burial 2 Cremation	3 Removal fro	m State	emetery, cre	osition (Name of matory or other place		Date	20c. Location - Cit	
Ë	Pag tment tant: jury c		`4 Donation 5 ☐ Other (S)	oecify)	Dular		ley Memorial				Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21 Signature of Funeral Service	chen /	make	10		6500 Y	Mitchell-Wie ork Road Balt	imore, Mary	land 21212
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one sause of	at caused the death n each line.	n. Do not en	ter the mode of dying	g, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a	LOWE	R	GI	BLE	ED		
	/Medical Examiner		1050Mily in dozally	Due	to (or as a consequ	uence of):					
e0 .	4 Avii	-ie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	to (or as a conseq	uarioù of)r					
V	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.							
ó	sician and burial-transit	Exa	resulting in death) Last		to (or as a conseq	uence of):					
68760,	ate be ex shysician the buria	llcai		d							
x 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c If yes	outcome of pregna	incv				23d. Date of	of delivery
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Liv	re birth 2 Feta	Ideath 3	□Ectopic pregnancy □ Other (specify)			Month	,
O.	that the de ned by the a detached f	ysi	1 □ Yes 2 □ №0 9 □ Unknown		known						
ر. ص	signed to	by P	Part II. Other significant condition	ons contributing to	o death but not res	ulting in the u	underlying cause give	en in Part I.	23e. Did t		ute to the cause of death?
ıd	w require been sig should b	ed t	- HD C		TF.,	<i>,</i>			10	Yes 2 TVIo 3	☐ Probably 4 ☐ Unknown
Records,	has be	Completed	Atrial	F16	rillot	zon			24a. Was	prio prio	re autopsy findings available in to completion of cause of
<u> </u>		Sol	Diabet	73 1	nelli.	FUS			perfo 1 ☐ Yes	rmed/ dea 212 No 1	ith? Yes 2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ac /	of Death (Check only		-
o	Phys r this ral dir	: To	1 ☐ Yes 2 ÎV No 27. Manner of Death			ER/Outpatie	nt 3 DOA	4 JF NU	rsing Home 5 Resi	dence 6 Other how injury occurred	(Specify)
Division	Attending Fir death. ector: After by the funer	tlon	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	9	ate of Injury fonth, Day Year)	Injury		<br Yes 2. []I	No		
Visi	Attenda r dea ector by the	ifica	3 Suicide 6 Could	100d 200. Pl	ace of Injury - At he	ome, farm, st	reet, factory, office		28f. Location (City or To		or Rural Route Number,
Ö	s afte el Dir ed in	Certification;	4 - Hornicae	00							
	To the Mospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyir (Check only one)	Exeminer: On th	the best of my kno e basis of examina nanner stated.	wledge, dea tion and/or in	th occurred at the time envestigation, in my op	ne, date an pinion, dea	d place, and due to the th occurred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifie	r)	1,00	29c. License	number		29d. Date signed (Month, Day, Year)
•			Barbar	11 (ANSM	11/1	xH D	38	392	1/8	12007
	6		30. Name and address of person	who completed o	ause of death (Item	n 23 (Type	, Print)	y W	1.06 7	CA	6610116
		ate	31. Date filed (Month, Day, Year)	32	Registrar's Signa	iture .	1	Y		7.00	EJOVILE,
	St Regist	ate rar	JAN 1 1	2007	Dieses d	1 As	and I			F	
				- 5							

Registrar DHMH 17 Rev 1/2001

GULIUS D'AMBROGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EDWARD 01 08 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Sex XX M 2□F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Director 218.40.0703 64 FEBRUARY 25,1942 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at 1 □Yes 2 □No Examiner must be notifled Director 28a-f ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23a by Funeral 8141 HARVEST CT. 21144 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 PYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 XXNO Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER STEEL 11 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental ပ VERA MILLER CHARLES DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau 8141 HARVEST CT SEVERN, MD 21144 GOLDIE KRUMM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MDVEICEM CROWNSV/ILLE 1.12.2007 CROWNSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FINK TUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 CRECORY XPINK M01148 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1 shock Enter the disease or heart failure Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) VENTRICULAR **Physician** /Medical Due to (or as a consequence of): Examiner 1) IABLACES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 □ No • 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops 1□ Yes 3 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ≥ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation Injury 2 🗌 No 1 Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and occurred at the time, date and place, and due to the 29a. Certifier Medical

hours after death. 24 hours after death e Funeral Director: within 24

> State Registrar

(Check only

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🛪 investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D006394

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year **Physician** Jamuäry 8, 7:13 P M Evelyn G. DeBaugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16, 1922 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 🔀 F 84 212-20-2443 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r 28a-f show a notified at 10d. Inside City Limits Director MD 1 ☐Yes 2 XNo Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 8820 Walther Blvd. 21234 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. suit: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No white Specify: ģ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Law Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Grolock Elsie Frev ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 West Pennsylvania Ave., Towson, Maryland 21204 Mr. Daniel Held/attornev Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland permit. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fu Service Licensee Coster 1050 York Road, Towson Maryland Ό. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local form the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consection of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4□ Nursing Home 5□ Residence 6 Stother (Specify) NOSPICE Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

I or Attending Physician: The law requires that the death certificate be executed after death. Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, thin 24 hours a within 24 hours a

Saltimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

AARON



m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WES

AR

ORIGINAL

29c. License number

29d. Date signed (Month_Day, Year)

7-00063 arl Jeffrey Davi	S	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene											
Physicia		1- For State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate o				Reg No.	200	7 0043				
ledical Exami		CARL JEFFREY DAVIS				Month January	Day	Year	0104 hrs				
		4a. Facility Name (if not institution, give street and number 3724 White Pine Road #A	or)	4b. City, Town, o Middle Rive	r Location of Death			ounty of Death					
Funeral Director			age (In yrs. last birthday)	If Under 1 Year Months Day		8. Date of E	Birth (MM/DD	Foreig					
		062.70.1705	21 Y	rs.	<u></u>	APRIL	28, 19	85 Co	ountry) NY				
ow any		10a. State 10b. County	10c City, Town or Loca	ation					10d. Inside City Limits 1 Yes 2 No				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	NY SULLIVAN 10e. Street and Number	LIBERTY	10f. Zip Code			10g. Citizer	of What Cou					
th the M. 23a or 2. notified		30 NORTH MAIN ST.		12754				USA					
eath wi	uneral	11. Marital Status 1 X Never Married 2 Married Armed Forces	s?X		spanic Origin? (Spe n, Mexican, Puerto R		lo- 14.	Race - Amer White, etc.	ican Indian, Black,				
after de	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 No	Yes 2 No	specify:		Sp	ecify: B	LACK				
hours 'natur		15 Decedent's Education (Specify only highest grade concluded to the secondary (0-12) College (1-4 of the secondary (0-12)	during		ition (Give kind of wo		16b. Kind	of Business/					
11215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "matural" event, the Medical Examine	Completed	10	<i>'</i>	ISH WASHER				RESTAURA	ЯТ				
5-0036 iled within 7 Hygiene. I other than the Medica		17. Father's Name (First, Middle, Last)		TOTT WAGHER	18.Mother's Name (F	First, Middle			41				
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than matic event, the Medical	To Be	BERNARD GOLDIE DAVIS 19a Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Stre	ESSIE LOU et and Number or Ru			or Town State	Zin Code)				
and 2 shou lealth and N tem 27 is n traumatic		ESSIE DAVIS	7		HTS RD. MONT				, zip code)				
프로프트		20a Method of Disposition 1 XBurial 2 Cremation 3 X Removal from 5	20b. Place of Dispo	osition (Name of ce		Date		ation - City or	Town, State				
im Pag ment tant: or of		4 Donation 5 Other Specific	LIBERTY CE		1.10.	.2007	LIB	ERTY, NY	1				
Balt permit Depart Impor injury		21 mature of Funeral Service (icensee) K. CREWORY FINK	FI		s of Facility . HOME, P.A. Y SW GLEN BU	IDNIE	MD 2106	1					
Physician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	ed the death. Do not enter	the mode of dying	, such as cardiac or r	espiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and				
/Medical Examiner	i	and the state of t	inshot wound of	head and	left am				Death				
	.	or condition resulting in death) Due to (or as a con Sequentially list conditions, b.	sequence on):										
	iner	if any, leading to immediate Due to (or as a concause. Enter Underping Cause	sequence of):										
sd ssit	Examiner	(Disease or injury that initiated events resulting in death) Last	sequence of)					-					
execui an and al - tra	ह	X UNPENDED d AMENDED 4	1920 27 200 £	ME -06	1 /0c /oz m				<u> </u>				
760, cate be physici	Med	IF FEMALE: 23c. If yes, outcome	23a,27,28a-f,	penul, goo.	3, 1/26/0/ T	<u>1</u>	23d D	ate of delivery	/				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	/sician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	et time of death	etal death 3 Other (Specify)	Ectopic pregnand	Ey	Mo	onth [Day Year				
hat the de ed by the letached f	by Phy		ath but not resulting in the	underlying cause	given in Part I.				the cause of death?				
rds, P.C	ted t					1 Y			bably 4 Unknown utopsy findings available				
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a page 3 should be a	Completed			· · · · · · · · · · · · · · · · · · ·		auto	opsy ormed?		completion of cause of				
tal Recirian: The certificate	Be	25. Was case referred to medical examiner?			Other Nursing								
of Viiing Physi	ا ا	1 Yes 2 No Impat 27. Manner of Death 28a. Date of In	ient 2 ER/Outpatier			Home 5 8d. Describe	Residence	e 6 ✔ Other	: Scene				
ion (tendin eath.	gie	1 Natural 5 Pending FNd 1/3/	'	:47 am	Yes 2 X No	subject	shot s	ælf					
Division of Attence after death Director: d in by the	ertification:	3 X Suicide 6 Could not be 28e. Place of	Injury - At home, farm, stre						ral Route Number, City e Pine Rd. #A				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier 1 Continue Physician To the heat of	House	urrod at the time, d									
Fo the Ho Within 24 h Fo the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of example and manner stated	amination and/or investiga										
F & F ŏ	Me	29b. Signature and title of certifier		29c. Licens					nth, Day, Year)				
		hy hu, ms		O.C.	M.E.		Janua	ry 3, 2007					
		 Name and address of person who completed cause of Ling Li, MD Assistant Medical Examine 		et, Baltimore,	MD 21201								
St			ar's Signat	we	_								

State 31. Date filed (Month, Day, Year) Registrar JAN 1 2007

			1 - For State Registrar	State of Marylar			of Health and of Death	l Mental Hy	giene 007 00437
Jr.	Physici		Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year
E.	/Medic Examir		Sara M. Farna 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tov	vn, or Location of De	Jan ath	2, 2007 12:10P ^M 4c. County of Death
2.7	<u> </u>		Malcolm Grow Medica 5. Social Security Number 6. Sex		(ant hirthday)	If Under 1 Y	Linton ear Monder 24 H	re 0 D	Prince Georges
-4	Funeral Director	7		7. Age (In yrs.	Yrs.		ays Hours Mi	n. (Month, Da	rth Ay, Year) 9. Birthplace (State or Foreign Country) 7. 1942 Daytona, F1
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	cation		11011	10d. Inside City Limits
	a-f she	ctor	MD Prince Ge	orges	Up	per Ma	rlboro		1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number			10f. Zip Co			10g. Citizen of What Country?
	ms 23	nerai	9900 Muirfield Dri	12. Was Decedent Ever in U		Vas Decedent	20772 of Hispanic Origin?	(Specify Yes or No	b- 14. Race - American Indian,
36	s after , or Ite	by Fui	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1964-		Yes, specify	Cuban, Mexican, Pu No <i>Specify:</i>	erto Rican, etc.)	Black, White, etc. Specify:
21215-0036	d within 72 hours after death with the Maryland piene. idene. It has natural, or Items 23s or 28s-f show the Marical Examiner must be natified at	ted b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	cation	16a. Decede	ent's Usual O	ccupation		White 16b. Kind of Business/Industry
121	within 7 ene. than "n he Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	one during most of watered)	rorking	
	I Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	4	<u> </u>	Major	18. Mother's N	ame (First, Middle	US AIr Force
ylan	should be nd Mental marked c	To B	Mitchell Drew				Thelm	na Hunter	Drew
Maryland	s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Type) Ray M. Farnum/Husb						er, City or Town, State, Zip Code)
øĵ.	of Heal	j i	20a. Method of Disposition	20b. F	Place of Dispos	ition (Name o	f	Date Mar	1boro MD 20772 20c. Location - City or Town, State
altimore,	permit. Pages of Department of Himportant: If Ite any injury or of another.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4XXDonation 5 ☐ Other (Specify)	How	ard Uni	iversit	:v lar	. 4, 200	7 Washington, DC
Bal	permit. Pa Departmer Important any injury		21. Signature of Funeral Service License Terry A. Austin		382	Name and Ad 21 1/1+ k	dress of Facility AL	ıstin Roy	ster Funeral Home shington, DC 20011'
968 2			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	n. Do not ente	r the mode of	dying, such as cardi	ac or respiratory a	rrest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Bladder Cance	er-Stag	e 4 wi	th Lung Me	etastasis	Onset and Death
	Examiner			Due to (or as a conseq	uence of):				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
<u>ر</u> ا	rate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
8760,	ate be hysicia the bur	licai	€ d.	-					
Box 6	Attending Physician: The law requires that the death certifical refers. Getor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregna	ıncy				22d Date of delivery
Ö.	ed for	siciar	in the past 12 months? 1 ☐ Yes 2 🎇 No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregna Other (specify			23d. Date of delivery Month Day Year
P.O.	that the ed by the detach	Phy	9 ☐ Unknown Part II. Other significant conditions cont		ulting in the unc	deriving cause	growen in Part I	23e Did to	obacco use contribute to the cause of death?
rds,	w requires been signo should be	ed by						1 X -X	
eco	e law requ has been je 2 shoul	Completed						24a. Was	
Division of Vital Records,	n: The flicate ! or, pag		25. Was case referred to medical					perfo	rmed? death? 2 No 1 ☐ Yes 2 ☐ No
>	nysicie nis cert direct	To Be	examiner?	ospital: 1 \(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\	ER/Outpatient	3□ DOA	Other	eath (Check only o	lne) dence 6 □Other (Specify)
0 00	After th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work?		now injury occurred
Visio	Attender death ector;	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	ome, farm, stree		I □ Yes 2 □ No ce	28f. Location (S	Street and Number or Rural Route Number,
٥	ospital or hours afte uneral Dire ly filled in t			building, etc. (Specify				City or Tow	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page:	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	er: On the best of my kno er: On the basis of examina and manner stated.	wledge, death of tion and/or inve	occurred at the estigation, in re	e time, date and place ny opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Hi within 24 To the Fu completel	Me	29b. Signature and title of centrier		Ø-	29c. Lic	ense number		29d. Date signed (Month, Dey, Year)
	4	-	Mulsay	(Cental	C.		1844-Ohio		Jan. 2, 2007
	17		30. Name and address of person who come Phillip J. Cover,			,	Rd, AAFB,	MD 2076:	2
	Sta Registr		31. Date filed (Month, Day, Year) 200	3. Registrar's Signa	ture	de l			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ARLENE GERTRUDE FLINTALL 2007 JAN. 09 7:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 419 RANDOM ROAD BALTIMORE CITY N/A 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 20 90 212-50-2957 Director 02/11/1916 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD N/A11√2 Yes 2 □ No BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 419 RANDOM ROAD USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2x ☐ No Specify: BLACK Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 Is marked other that any Injury or other traumatic annote. HOUSEKEEPER 12TH DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ EDDIE BRYANT BESSIE FALLIN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNETTE Y. FLINTALL/DAUGHTER 419 RANDOM ROAD, BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 01/16/07 LANSDOWNE, MD 21. Signature of Timeral Service Licensee HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, 23a. In the first the disease, or complications that caused the deal shifts, in least finure. List only one cause on each line. Immedia Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Due to (or as a consequence of): **Physician** /Medical Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has 1∐ Yes 2. 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2/100 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

P.0. Division or Vital Records,

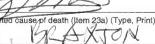
3altimore, Maryland 21215-0036

be executed funeral director, After t Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu To the Hospital within 24 hours at To the Funeral

State Registrar

30. Name and address of person who come

29b. Signature and title of certifier



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 0000516

STI

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier (Check only one)

4 | Homicide

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

DHMH 17 Rev 1/2001

07-00093 Nijiaha Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

vijiana i iankiin		State of Maryland / De 1-For State Registrar	•	t of Health an e <i>of Death</i>	id Mental F	75	Reg. No. 200	7 001.2
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)		Franklin	<u> </u>	2. Date of Dea Month	ath Day Year	3. Time of Death
		4a. Facility Name (if not institution, give street and number)			r Location of Deat	January 4	4c County of Deat	0652 hrs
		Sinai Hospital		Baltimore		_		
Funeral Director		/-	rs. last birthda	Months Day		1.	Forei	
		N/A 1 M X F Usual Residence of Decedent		Yrs 01 2	7	11 0	8 2006 ^{cc}	ountry) MD
ow any			City, Town or L				-	10d Inside City Limits
Aaryland 28a-f show Lat once.	ctor	MD NA 10e. Street and Number	Balti	10f. Zip Code			Og. Citizen of What Cou	1X Yes 2 No
the Ma is or 28	Dire	MD NA 10e. Street and Number 2814 Oswego Ave			215		U.S.A.	nu y r
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	n U.S. 13	. Was Decedent of His If Yes, specify Cubar				can Indian, Black,
Rer dea		1 Yes 2 N 3 Widowed 4 Divorced If Yes, Give Year		Yes 2X No		rtiodri, etc. j		Black
hours afte 'natural'', Examiner	ed by	or Dates: 15. Decedent's Education (Specify only highest grade completed)	d) 16a. Dece	edent's Usual Occupa	tion (Give kind of	work done	16b. Kind of Business/	
36 nin 72 h	Completed	Elementary/Secondary (0-12) N/A N/A N/A	duiii	N/A	. DO NOT use ret	irea)	N/A	
21215-0036 wild be filed within 72 Mental Hygiene. marked other than " c event, the Medical I	Сош	17. Father's Name (First, Middle, Last)		N/A	18 Mother's Name	e (First, Middle, I	Maiden Surname)	
12 d be lenta	Be	Gilbert Franklin 19a. Informant's Name/Relationship (Type, Print)			-	Willia		
MD 2 ad 2 shoul alth and M m 27 is m aumatic	То	Tonya Williams-Mother		14 Oswego			ore, Md	Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and 1 tant: If item 27 is ror or other traumatic			0b. Place of Dis	sposition (Name of cer or other place)		Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Openation 5 Other Specify:	ing Me	emorial H		10/07	randalls	town, Md
Baltimore, MD 2 permit. Pages and 2 shoul Department of Health and N Important: If iten 27 is m injury or other traumatic.		21. Shirletu of Funeral Service Licensee	ĺ	22. Name and Address March F/I	of Facility H West	5 1.		01015
Physician		23 Part I. Enter the disease, or complications that caused the de failure. List only one cause on each line.	ath. Do not en	ter the mode of dying,	such as cardiac of	r respiratory arm	imore, Md	21215 Approximate Interval
/Medical Examiner		mmediate Cause (Final disease a Sudden unexplai		h in infancy				Between Onset and Death
represent the second of the se	4	or condition resulting in death) Due to (or as a consequence b	ee of).					
	iner	if any, leading to immediate Due to (or as a consequence cause Enter Underlying Cause	e of):					
\do \a_{\bar{\c}{2}} \end{array}	Examine	(Disease or injury that initiated events resulting in death) Last	e of):					
760, Cicate be executed physician and the burial - transit	Medical	X UNPENDED d.	ME	0005 0/7/0				
760, icate be physicia the buria		X UNPENDED #23a, 27, 28a-f, IF FEMALE: 23b. Was decedent pregnant in the	per ME,	G865, 3///0	/ TT		23d Date of delivery	
Box 687 death certific	ician	past 12 months?	2 death 5	Fetal death 3 Other (Specify)	Ectopic pregna	incy	Month D	ay Year
P.O. Box 68; that the death certifi ned by the attending detached for use as t	Physician/	1 Yes 2 No 9 Unknown 9 Unknown						
P.O.	2	Part II. Other significant conditions contributing to death but no	ot resulting in t	he underlying cause g	iven in Part I.		bacco use contribute to t	
ords, P.C w requires that s. been signed b	Completed			_		24a Was a		opsy findings available
tal Reco cian: The law certificate has	ошо					autop: perfor	med? death?	ompletion of cause of
Vital Rysician: Tysician: This certific director, p	Bec	25. Was case referred to medical examiner?			of Death (Check		No 1 Yes	s 2 No
Division of Vital Records, lat or Attending Physician: The law requirers after death at Director: After this certificate has been so led in by the funeral director, page 2 should be	٤	TO TOS Z NO	✓ ER/Outpati		Other Nursin		Residence 6 Other	
ion C tending eath tor: Af	Ęį	1 Natural 5 Pending D 1 1// (2005		1 1 Y	es 2 X No	unknown	ow injury occurred	
Divisi pital or Att ours after de eral Direct filled in by	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - A	Fnd 5; t home, farm, s	treet, factory, office b	uilding, etc.	28f. Location (S	treet and Number or Run	al Route Number, City
lospital		30s Caddies -	in resid			Baltimore		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending Completely filled in by the funeral director, page 2 should be detached for use as it	Medical	Check only one) 2 Medical Examiner: On the basis of examination and manner stated	ledge, death oo n and/or invest	ccurred at the time, da igation, in my opinion,	te and place, and death occurred a	due to the cause t the time, date a	e(s) and manner as state and place, and due to the	d cause(s)
	ž.	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mon.	th, Day, Year)
Ser		Muna Brassell, M.D.	0.5	O.C.N	Л.Е. 		January 4, 2007	
φ		 Me and address of person who completed cause of death (It Melissa Brassell, MD Assistant Medical Exan 		1 Penn Street, B	altimore, MD	21201		
	-13	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature	20 B				
Registrar JAN 1 1 2007 June 16 April 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Laura Mary Gensicki January 7,2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death

Yrs.

10c. City, Town or Location

7. Age (In yrs. last birthday)

Essex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Months

3. Time of Death

Baltimore Co.

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

8. Date of Birth (Month, Day, Year)

Aug. 8,1915

3:30 PM

/Medical **Examiner**

Funeral

Riverview Nursing Home

1 □ M 2 ☑ F

5. Social Security Number

10a. State

215-42-7317
Usual Residence of Decedent

Director

burial-tra Box 68760 O. signed by t Division or Vital Records, P. nas e 2 e page certificate this death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examples. Edgemere Baltimore 1 ☐ Yes 2X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road Apt. 310 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Housewife Own Home 17. Father's Name (First, Middle, Last, Be 18. Mother's Name (First, Middle, Maiden Surname) Theodore Michalski Rose Muzvn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Glascock (Daughter) 409 Delaware Ave. Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State M⊠Burial 2 □Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Ht. of Mary Cem. 1/10/2007 Dundalk, Maryland 2 Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Munoria /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: ٩ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 TYes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006190 08 30 Name and address of person who completed cause of death (Item 23a) (Type, Print 1124 Mace nukwuma Treque 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN 1 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Õ9, 2007 06:07 a.^M Rosemary T. Grantland January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 12, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours 75 1931 Maryland Director 213-26-9741 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b County 1 X Yes 2 □ No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Iner must be no 21239 United States 6401 Loch Raven Blvd. Apt. 533 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Annello Culotta Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 7426 Kenlea Ave. Mr. Michael Sarro / Husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Jan. 11, 2007 Parkwood Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Funeral Director: within 24 I T

State

Medical

29a. Certifier

29b. Signature and title of certifier

CARLSPERYNG,

31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

5601 LOCH RAVEN BLVD

ORIGINAL

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28987

BALTO.

29d. Date signed (Month, Day, Year)

1-9-07

MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** TRENT SHERIDAN GALLOWAY 10, JANUARY 2007 3:35 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F DELAWARE 215-09-5833 Yrs Director 91 10/13/1915 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 🛣 No Director TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12261 ROUNDWOOD ROAD UNIT# 1115 or Items 23a 21083 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. es 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2 🛣 No þ Specify: Specify: WHITE X Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MERCHANDISER MONTGOMERY WARDS 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES GALLOWAY EVA MAY SMITH ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IANUARY 10, permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traum once. SEAN O'CONNOR/NEPHEW 239 WEST MEDWICK GARTH CATONSVILLE, MD 21228 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 1/15/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DISSECTING AORTIC ANEURYSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as been signed by the aftending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 1∐ Yes 2 X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2**X** No Medical Certification: To 1 [Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural s after death. I Director: A od in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

TRENT GALLOWAY

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

725

29d. Date signed (Month, Day, Year)

07-00179 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Yule Henderson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner Month Day January 7, 2007 HENDERSON 0031 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Johns Hopkins Hospital Baltimore N/A 5. Social Security Number **Funeral** 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 4,1985 Foreign Director Months Davs Hours 215 08 2623 21 $_{1}[X]_{M}$ Mar. 2 F Usual Residence of Deceden anv 10c. City, Town or Location 10d Inside City Limits or 28a-f show , or items 23a or 28a-f sho r must be notified at once. X Yes 2 No hours after death with the Maryland MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country LAFAYETTE AVE. 21213 2400 E. USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Specify BLACK Divorce Yes, Give Year 1 Yes 2 X No specify "natural", Examiner <u></u> 15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) d other than "n Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. llTH LABOR "R" TEMPS US 17 Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Important: If item 27 is marked injury or other traumatic event, t Be YUL A. HENDERSON, SR. JACQUELINE WRIGHT 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code BALTIMORE, MD. JESSIE HENDERSON/grandmother 2400 E. Lafayette ST 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Baltimore, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify MT.ZION CEM JAN.18,2007 BALTO,MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 F. PRESTON ST. BALTO, MD. nature of Funeral Service Licensee **Physician** Part I. Enter the disease, or complications that caused the der the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and tran: Physician/Medical UNPENDED AMENDED ourial Division of Vital Records, P.O. Box 68760, attending phys or use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Month Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes 2 No 25 Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 1 🗸 Yes 2 DOA Nursing Home 5 Residence 6 Other

MD.

Year

After this certificate has been Director:

To the Hos ital or A tending Physician: 24 hours after death To the Funeral D

Certification:

Medical

State Registra

28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural FOUND: Subject was shot 5 Pending 1 Yes 2 V No Jan 7, 2007 0001 hrs Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1800 Block of North Montford Avenue, Baltimore, MD determined (Specify) Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OCME January 7, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

07-00092

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John M. Hart		State of Maryland / Department of Professional State of Maryland / Department of Certificate of Registrar		ygiene Reg. No	2007 0044
Physici Medical Exam		JOHN MICHAEL HART		2. Date of Death Month Day January 4, 200	Year 3 Time of Death 0415 hrs
		4a. Facility Name (if not institution, give street and number) 3113 Cedarhurst Road	4b. City, Town, or Location of Death Baltimore	4	c. County of Death
Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs Months Days Hours Min.	8 <u>2 eterpf Both</u> (MN 01/04/200	M/DD/YYYY) 9. Birthplace (State or
ne Maryland or 28a-f show any	tor	Usual Residence of Decedent 10a. State	tion		10d. Inside City Limits 1X,XX es 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	3113 Cedarhurst Road	10f. Zlp Code 21214	10g Cit	tizen of What Country? USA
r death w or items must be	by Funeral	or Dates:	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 XX No specify.	Rican, etc.)	14 Race - American Indian, Black, White, etc. Specify: White
b, MD 21215-0036 and 2 should be filed within 72 hours after lealth and Mental Hygiene, ten 27 is marked other than "matural", traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last)	nt's Usual Occupation (Give kind of whost of working life. DO NOT use retiremptogen	ork done ed) ,16b. (First, Middle, Maider	N/A
21215 Id be file Aental Hy narked o	o Be C	Leonard Richard Hart Jr	Mary Jai	ne Jacobse	n
MD 2 nd 2 shou aith and N m 27 is n	ř	Phyllis M Hart Sister 3030	g Address (Street and Number or R Pinewood Avenue		
- ESO		20a. Metriod of Disposition 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other Specify	sition (Name of cemetery, her place) Crematory 01/0	Date 20c. Date B	Location - City or Town, State altimore, Maryland
Balt permit. Depart Impor injury		VWIVIUS XHULUM IEMINISIA)	Name and Address of Facility Mito	Road Baltimor	re Marryland 21212
Physician /Medical Examiner	iner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter to failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate. Due to (or as a consequence of): Due to (or as a consequence of):	he mode of dying, such as cardiac or	respiratory arrest, sho	Approximate Interval Between Onset and Death
ecuted and - transit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60, ate be exe ohysician a	Medical	X UNPENDED X AMENDED 8 per fh g863	1-12-07 vt //#23a,2		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ot 9 Unknown	tal death 3 Ectopic pregnanther (Specify)		Date of delivery Month Day Year
ires that the signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I		use contribute to the cause of death? No 3 Probably 4 V Unknown
Division of Vital Records, P.O. rate of Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			24a Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital hysician: this certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check or 3 DOA Other Nursing		nce 6 🗸 Other Scene
ion of tending Pt eath. tor: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1/4/2007 4:15 am		Red. Describe how inju subject in h	
Divisi spital or Att tours after de neral Direct	Certification:	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) 3113 Cedarhurst	et, factory, office building, etc 2		nd Number or Rural Route Number. City
To the Hos within 24 h To the Fur completely	Medical	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated	red at the time, date and place, and dion, in my opinion, death occurred at	ue to the cause(s) and the time, date and place	d manner as stated ce, and due to the cause(s)
	W	29b Signature and title of certifier Mussa Grassell M.D. 30 Name and address of person who completed cause of death (Item 23a)	29c License number O.C.M.E.		Date signed (Month, Day, Year) Uary 4, 2007
Ø	ate	TALL D. HARD.	enn Street, Baltimore, MD 2	1201	
Regist	rar	JAN 1 1 2007 Jane 18 April	12.0		
DHMH 17 Rev 1/20 OCMF 2006	001	ORIGINAL	_		

07-00189 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rameez Hearn State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar t's Name (First, Middle,Last) Physician/ 2. Date of Death Month January 7, 2007 **Medical Examiner** 1028 hrs 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year Funeral 7. Age (In yrs last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State of Foreign Director Davs 12-77 1 X M 2 Usual Residence of Decede 10a. State 10b. County Oc. City, Town of Location 10d Inside City Limits 28a-f shov Yes 2 notified at once. timore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral . Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or Noes I and 2 should be filed within 72 hours after death wi of Health and Mental Hygiene. If item 27 is marked other thau "natural", or items ther traumatic event, the Medical Examiner must be 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married White, etc. Yes Divorced Yes, Give Year Widowed Yes 2 No specify ş 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 N/A N/A s Name (First, Middle, Last) First, Middle, Maiden Surname Wion ump Informant's Name/Relationship (Type, Print) 19b Mailing Address or Rural Route Number, City or Town, State, Zip Code) MD 21217 Method of Disposition Baltimore, Place of Disposition (Name of cemetery 20c Location - City or Town, State crefnatory or other place) Cremation 3 Removal from State Denation 5 Other Specify ature of Fun r# Service eer Baltimore Balto 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure List only Between Onset and /Medical Sudden Unexplained Death in Infancy (SUDI) Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and fran: d Physician/Medical XUNPENDED AMENDED, 27, 28a-f, perME. g866, 4/9/07 TT #15,16a-b, perFH Box 68760 IF FEMALE ing phy: 23d Date of delivery 23b Was decedent pregnant in the past 12 months? Ectopic pregnancy Fetal death Month Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? \$ Completed has been 24a Was an autopsy performed? death? page ✓ Yes 2 ✓ Yes 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner?

Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requir this certificate After Director: d in by the f within 24 hours a To the Funeral I

Yes 2 No 3 Probably 4 🗸 Unknown 24b. Were autopsy findings available prior to completion of cause of No Hospital. Other₄ Inpatient 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 1 🗸 Yes 2 No Other Manner of Death 28a. Date of Injury (Month, Day,Year 28c. Injury at Work? 28b. Time of Injury 28d Describe how injury occurred Natural 1 Yes 2 X No 5 Pending Fnd 1/7/2007 2 Fnd 9:45 am Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number. City or Town, State) 1621 Druid Hill Ave. Apt Baltimore, MD 3 X Could not be Suicide determined (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie

State

io.

Certificati

Medical

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

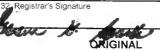
29d Date signed (Month, Day, Year)

January 8, 2007

29c. License number

O.C.M.E

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:37 AM Eleanore Lillian Hartley anuarc 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 76 Director 381-24-3732 Feb. 12, 1930 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 € Yes 2 No Maryland Prince George's Lanham Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 8308 Nightingale Drive 20706 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Honeywell 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian J. Walatka James Preston Jennings ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann Marie Santilli - Friend 2N Plateau Place, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery Jan.11,2007 21. Sign threat Fundal Service Lyansee 22. Name and Address of Facility 4739 Baltimore Ave. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyattsville, MD 20781 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) disease 4 d Vanced Physician /Medical Due to (or as a consequence of): epsi **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed 0 XIC and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? n or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Marobably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🗷 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0062594 01/06/

State

Registrar

NASHAT 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATAILLA

7525 Greenway Center Dr. Sutil 113 Granbelt MD

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. UU 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5,2007 Sr. M. Monica Hundertmark, RSM January 3:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Villa Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-12-1921 9. Birthplace (State or Foreign Country) Hawaii **Funeral** Days Hours 1 □ M 2 □ F 220-54-8353 85 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified. Director 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bellona Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify. 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman W. Hundertmark Agnes E. Saunders ၉ 19a. Informant's Name/Relationship (Type. PrintReligious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 Sisters of Mercy 0rder 1300 E. Northern Parkway, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 1-8-07 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral HOme, 21. Signature of Funeral Service License PA, 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** fa. lu 1 wack /Medical Due to (or as a consequence of): **Examiner** Atherosclento Cardovasular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been si e 2 should l 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate death? 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🔲 Inpatient After this 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031865 mien 30. Name and address of person w no completed cause of death (Item 23a) (Type, Print) oppa Rd mien-poor Kiture Towson mo

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 1

2007

32, Registrar's Signature

		FOR	epartment of Health and M Certificate of Death	ntal Hygien Reg. N	2007	00448
		Registrar Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physici		Neil George Hamr	ick, Sr.	Month D January	6.2007	5:40 P ^M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	<u> </u>
		1918 Denbury Road	Dunda1k			ore Co.
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Coun	lace (State or Foreign try)
Director		233-66-8722 62	5.	Nov. 4,19	44 Wes	t Virginia
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		1	0d. Inside City Limits
be filed within 72 hours after death with the Maryland tall Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	5		,	D 4 - 11-		1 □Yes 2 No
the 1 28a- notifi	Director	Maryland Baltimore	10f. Zip Code	Dundalk 10g. (Citizen of What Coun	itry?
3a or		1918 Denbury Road	21222	Un	ited State	es
death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 		14. Race - Americ Black, White,	an Indian,
after or ite		Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never 1 N	1 ☐ Yes 2 ☑ No Specify:	Thoan, etc.)	Specify:	etc.
ral"; C	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Wh:	ite
be filed within 72 hattal Hygiene. d other than "natuevent, the Medical	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	sing 16b.	Kind of Business/Inc	dustry
ithin han a	ldm	Elementary/Secondary (0-12) College (1-4or 5+)				
led w Hygie her ti		12 Years Pr. 17. Father's Name (First, Middle, Last)	oduction Supervisor	e (First, Middle, Maide		kaging Co.
ntal he f	Be	Carl Lee Hamrick		Maude Luci		
Il yidliu ZIZ should be filed within nd Mental Hygiene. marked other than imatic event, the M	2		lailing Address (Street and Number or Rur			Code)
e, index yidation 2 1.X. 1 and 2 should be filed with: Health and Mental Hygiene, em 27 is marked other than ther traumatic event, the			918 Denbury Road D	undalk, Ma	ryland 2	1222
Hear tem		cemetery	isposition (Name of crematory or other place)	Date 20c.	Location - City or To	wn, State
ages ent of ht: If I		1 XBurial 2 Cremation 3 Removal from State	on Forest V.A. Cem.	1/12/2007	Owings D	Mills, MD
permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Selvice hicensee	22. Name and Address of Facility			
Depariment of the service of the ser		Month of the lost	Duda-Ruck Funeral 7922 Wise Ave. D	undalk, Ma		1222
* 3.5		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician			Um-Small (e)	11 lung	Concet	Onset and Death
/Medical		resulting in death) Due to (or as a consequence of)	:			
Examiner	_	Sequentially list conditions, bb.				
pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
xecut and II-tran	Examiner	that initiated events c	:			
cate be executed physician and the burial-transit	dical E					
g phy as the	edic					
h cert anding	N/	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delive	•
death death death death death	sician/Me	1 Tree past 12 months? 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Phys	9 □ Unknown				
gned gned	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	<	o use contribute to the	
w requires to been signer should be or	e			1) Yes	2 No 3 Prob	ably 4 Unknown
law ras be	Completed			24a. Was an autopsy	prior to con	psy findings available mpletion of cause of
The ate h	Omo			performed 1□ Yes 2D	No death? No 1 ☐ Yes	2□ No
clan: Gertifica	Be (25. Was case referred to medical examiner?		th (Check only one)		
hysic this c	2		atient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 28d. Describe how in	6 □Other (Specif	y)
ing F After Tuner	ion:	1 Natural 5 Pending (Month, Day Year) Inju		20d. Describe now in	ijury occurred	
Attending ar death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm		28f. Location (Street	and Number or Rura	J Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ate)	
spita nours ineral		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cause	e(s) and manner as s	tated.
he Ho in 24 I he Fu pletel	Medical	(Check only one) Medical Examiner: On the basis of examination and and manner stated.		rred at the time, date a	and place, and due to	o trie cause(s)
Vithi To t	Σ	29b. Signature and title of codified	29c. License number	29d. [Date signed (Month,	Day, Year)
(U		MAN HASIC	ian 144969		1/8/0	+ 71771
51		30. Name and address of berson who completed cause of death (Item 23a) (T	/pe, Print)	avo a	م الخدم	~ Marin
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	TO EUSTRII	UIVE, E	JU MAIN	110, 11 10
St: Regist	ate rar	JAN 1 1 2007	dreets)			
		ALLEN T T TOOL VERTING 12.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** January 8, Charles Harrison 2007 11:30Å */Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**0M 2□ F Yrs. Maryland 1924 82 **Director** 219-18-8532 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Lutherville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 21093 U.S.A. 117 Greenridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 shoulc be filed within 72 hours efter Department of Health and Me tall Hygiene. Important Health and Me tall Hygiene. Important flem 27 is marke other than "natural", or lite any injury or other traumatic event, the Medical Examine. 1 Y Yes 2 □ No If Yes, Give 1943-1945 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Carpet Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ William Harrison, Sr. Frieda Speilmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7130 Greenbank Road Baltimore, Maryland Friend <u>Kilchenstein</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-12-2007 Parkville Maryland 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility 21. Signa Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 propatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 W 31. Date filed (Month, Day, 32. Registrar's Signature State College Grand Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		. Decedent's Name <i>(First, Middl</i> e, Paul	, Last) Josep	oh	Hardaway Sr.	2. Date of Dea	o5 200	3. Time of Death 8:33a. N
dical niner	48	a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of Deat Baltimore	h	4c. County of Deat	th
al		2737 Beryl Av	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreig
or	1	218-44-9035	1 X M 2□ F	91 Yrs.	Months Days Hours Min.	03 ^{(Month} 30	1915 Co	VA
	-	Sual Residence of Decedent Oa. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits
ctor		MD NA	1	Baltimor	: e			1 X Yes 2 No
Dire	10	0e. Street and Number	••		10f. Zip Code 21205		Og. Citizen of What Co	ountry?
Jeral	1	2737 Beryl Av 1. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-		
Fur		1 Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2 ☒ No Specify:	to filcari, etc.)		e, etc. lack
Completed by Funeral Director	-	3 ☐ Widowed 4 ☐ Divorced 15. Decedent	Year or Dates:	16a. Dece	dent's Usual Occupation		16b. Kind of Business/	
plet	. -	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5	(Give	e kind of work done during most of wo DO NOT use retired)	rking	Beth Ste	•
Com		6th grade	na	Sı	teel Worker	me (First, Middle,		er corb
To Be	1,	7. Father's Name (<i>First, Middle, I</i> Harda William Hard:	way		1 .	DeHave		
once. To Be Completed by Funeral Director	1	19a. Informant's Name/Relationsh Patricia Mars	ip (Type. Print)		ng Address <i>(Street and Number or R</i> 29 Orth Road,	ural Route Numbe Ba lti mo	r, City or Town, State, 2	Zip Code) 1219
	2	0a. Method of Disposition	O CI Domoval from Chata	20b. Place of Disponentery, cre	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State
		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)			1/07	Farmville	, VA
i dice	2	21. Signature of Funeral Service I	Licensee	M_{Λ}^{2}	2 Name and Address of Facility arch F/H West 300 Wabash Ave	. Balti	more, Md	21215
	2	23a. Part1. Enter the disease, or	complications the caused	the death. Do not en	ter the mode of dying, such as cardia			Approximate Interval Between
n		shock, or heart failure. List of mmediate Cause (Final disease or condition	only one cause on each life	DNI	Renal fai	lure.		Onset and Death
al er	r	esulting in death)	Due to (or as	a consequence of):				
	1 5		- HUD	DUTENS	IDM			
	11	Sequentially list conditions,	Due to (or as	a consequence of):	TUTY			Soyes
amine	ti	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (grass	- 1 mm				soges
Examiner		Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	с	- 1 mm				soges
<u>5</u>		rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	с	a consequence of):				SOGRS
<u></u>		F FEMALE: 23b. Was decedent pregnant	c	a consequence of): a consequence of): pf pregnancy			23d. Date of del	•
<u>5</u>		FEMALE: 23b. Vas decedent pregnant in the past 12 months?	c	a consequence of): a consequence of): pf pregnancy □ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	livery Day Year
20.		F FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	a consequence of): a consequence of): pf pregnancy 2 ☐ Fetal death 3 time of death 5	⊒Ectopic pregnancy □ Other <i>(specify)</i>	23e. Did to		Day Year
20		FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c	a consequence of): a consequence of): pf pregnancy 2 ☐ Fetal death 3 time of death 5	⊒Ectopic pregnancy □ Other <i>(specify)</i>	23e. Did to	Month bacco use contribute to	Day Year of the cause of death?
<u></u>		FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c	a consequence of): a consequence of): pf pregnancy 2 ☐ Fetal death 3 time of death 5	⊒Ectopic pregnancy □ Other <i>(specify)</i>	1 □ Y 24a. Was a	Month bacco use contribute to es 2☑No 3☐Pr	Day Year the cause of death? robably 4 Unknow
		FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c	a consequence of): a consequence of): pf pregnancy 2 ☐ Fetal death 3 time of death 5	⊒Ectopic pregnancy □ Other <i>(specify)</i>	1 ☐ Y 24a. Was a autop perfor	Month bacco use contribute to es 2 No 3 Pr an 24b. Were au sy med 2 death	Day Year the cause of death? robably 4 Unknow
Be Completed by Physician/Medical	P	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No. 9 Unknown 2art II. Other significant conditions.	c	a consequence of): a consequence of): pf pregnancy 2 Fetal death 3 time of death 5 l	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	1 Y 24a. Was a autop perfor 1 Yes ath (Check only or	Month bacco use contribute to es 2 No 3 Pr an 24b. Were at prior to death? 1 Yes ne)	Day Year of the cause of death? robably 4 Unknow utopsy findings availab completion of cause of
To Be Completed by Physician/Medical	P - 2	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2art II. Other significant conditions. 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	c	a consequence of): a consequence of): pf pregnancy 2 Fetal death 3 time of death 5 time of death 6 time of	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of De nt 3□ DOA Other: 4□ Nursing	1 Y 24a. Was a autop perfor 1 Yes ath (Check only on the second of	Month bacco use contribute to tes 2 No 3 Pr to tes 24b. Were at prior to death? 1 □ Yes	Day Year of the cause of death? robably 4 Unknow utopsy findings availab completion of cause of
To Be Completed by Physician/Medical	P - 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2art II. Other significant conditions. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident	C. Due to (or as d	a consequence of): a consequence of): pf pregnancy 2 Fetal death 3 time of death 5 ut not resulting in the unit 2 ER/Outpatie ry y Year) 28b. Time of linjury	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of De 26. Place of De 1 □ Versing 28c. Injury at Work? 1 □ Yes 2 □ No	24a. Was a autop perfor 1 Yes ath (Check only or Home 5 Resid	Month bacco use contribute to es 2 No 3 Pr 24b. Were au prior to death 1 Yes ne) ence 6 Other (Spe ow injury occurred	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year
To Be Completed by Physician/Medical	P - 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	C. Due to (or as d	a consequence of): a consequence of): pf pregnancy 2 Fetal death 3 time of death 5 time of death 6 time of d	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of De 26. Place of De 1 □ Versing 28c. Injury at Work? 1 □ Yes 2 □ No	24a. Was a autop perfor 1 Yes ath (Check only or Home 5 Resid	Month bacco use contribute to es 2 No 3 Pr an yield	Day Year The cause of death? Trobably 4 Unknow Untopsy findings availab completion of cause of 2 No
Certification: To Be Completed by Physician/Medical	P	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant condition 27. Manner of Death 1 Natural	Due to (or as d	a consequence of): a consequence of): pf pregnancy 2	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of De 26. Place of De 1 □ Versing 28c. Injury at Work? 1 □ Yes 2 □ No	24a. Was a autop perfor 1 Yes ath (Check only or Home 5 Resid 28d. Describe h	Month bacco use contribute to les 2 No 3 Pr an	Day Year Day Year Day Year Day Year Day Year Day Year
To Be Completed by Physician/Medical	2 P	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions around the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions around the past 12 months? 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manger of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 4 Homicide 4 Homicide 22 Medical 2 Medical 3	Due to (or as d	a consequence of): a consequence of): pf pregnancy 2	□Ectopic pregnancy □ Other (specify) □ underlying cause given in Part I. 26. Place of De nt 3□ DOA Other: 4□ Nursing Indicate the Section of Section 1 □ Yes 2□ No reet, factory, office th occurred at the time, date and place onvestigation, in my opinion, death occurred at the time, date and place onvestigation, in my opinion, death occurred at the time, date and place onvestigation, in my opinion, death occurred at the time, date and place onvestigation, in my opinion, death occurred at the time, date and place onvestigation, in my opinion, death occurred at the time, date and place of the occurred at the occurred at the time, date and place of the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the	24a. Was a autop perfor 1 Yes ath (Check only or 28d. Describe here, and due to the courred at the time, of 28d.	Month bacco use contribute to les 2 No 3 Pr an	Day Year o the cause of death? robably 4 □Unknow utopsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. e to the cause(s)
Certification: To Be Completed by Physician/Medical	2 P	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 27 Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying one)	Due to (or as d	a consequence of): a consequence of): pf pregnancy 2	□Ectopic pregnancy □ Other (specify) □ underlying cause given in Part I. 26. Place of De nt 3□ DOA Other: 4□ Nursing of □ 28c. Injury at Work? ■ 1□ Yes 2□ No reet, factory, office th occurred at the time, date and place nvestigation, in my opinion, death occ	24a. Was a autop perfor 1 Yes ath (Check only or 28d. Describe here, and due to the courred at the time, of 28d.	Month bacco use contribute to es 2 No 3 Pr an prior to death? 24b. Were at prior to death? 1 Yes ne) ence 6 Other (Spe ow injury occurred treet and Number or Re cause(s) and manner as date and place, and dece	Day Year o the cause of death? robably 4 Unknow utopsy findings available completion of cause of 2 No cify) ural Route Number, s stated. e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0¹7^y 2007 8:37р.м **Physician** Higgins Beatrice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 1536 Moreland Ave
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.

 1 2
 1 4
 2 2
 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 84 VA 216-16-8564 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at X□Yes 2□No NA Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Marth Hygiene, and I file may 21 is marked other than "natural", or Items 23a or : ury or other traumatte event, the Medical Examiner must be I ury or other traumatte event, the Medical Examiner must be I. U.S.A. 21216 1536 Moreland Ave by Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) lementary/Secondary (0-12) School System Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Irvin Lindsay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3232 Belmont Ave, Baltimore, Md Paulette Medley-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Md Garrison Forest Vet 1/16/07 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Implediate Cause (Final MYOCARDIAL INFARCTION HCUTE **Physician** OHE HOUR sease or condition sulting in death) /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE WITH ISCHEMIC CARDIOMYDPATHY DRONARY FOUR YEARS Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical NA NA IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL HYPERTENSION -LONGSTANDING 1 Tes 2 No 3 Probably 4 Unknown MZICIORPHTEGYH, HYPER LIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No ATRIAL FIBRILLATION, DNIC 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 687605 Vital Division or

completely

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

29c. License number

29d. Date signed (Month, Day, Year)

leraufur Kawal

D18362

1-8-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Swite LL10. Balto. Md 21229

State Registrar

within 24 hours a

			- For	partment of Health and I	Mental Hygi	ene	
				ertificate of Death	Re	g. No. 200	7 00452
П	Physicia	an a	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
70.	/Medic		Robert Kenneth Hamilton		January		4:23 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	
			Home; 39 Wiltshire Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Essex If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimor	e County hplace (State or Foreign
и	Funeral Director		214-26-6598 12 T T T T T T T T T T T T T T T T T T	Months Days Hours Min.	(Month, Day,	Year) Co	ryland
is .			Usual Residence of Decedent		1.0 10 12	114	
	rylan how		10a. State 10b. County 10c. City, Town or	_			10d. Inside City Limits
	e Ma Ba-f s	cto	Maryland Baltimore Co.	Essex			1 ☐Yes 2¶ No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	·
	s 23e	eral	39 Wiltshire Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	21221 3 Was Decedent of Hispanic Origin? (S	necify Ves or No-	US 14. Race - Ame	
	flied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	o Rican, etc.)	Black, Whit	
920	urs af al', or Exam	þ	3 ☐ Widowed XX Divorced if Yes, Give Year or Dates: Korea	1 ☐ Yes 2CXN o <i>Specify:</i>		Specify:	white
Õ	2 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation	kina 1	6b. Kind of Business/	Industry
2	ithin 7 16. 18n "i	nple	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of wore. DO NOT use retired)	9	C-16 D-1	
7	led w lygier her th			staller	ne (First, Middle, M	Self Emplo	oyeea
and	be findal Ped otl	Be	17. Father's Name (First, Middle, Last) Luther Hamilton	_	e Mooney	aluen Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. If Health and Mental Hygiene than "natural", or items 23a or 28a-f show tem 21 is marked other than "natural" or items 20 or 28a-f show other traumatic event, the Medical Examiner must be notified at	은		uiling Address (Street and Number or Ru		City or Town. State. 2	Zip Code)
Σ	and 2 s ealth ar n 27 Is wer trau			8 Stansbury Mill R			. ,
re,	s 1 and 2 of Health Item 27 other tr		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)		Oc. Location - City or	
altimore,	Φ ·		11 Burial 24 Cremation 31 Hemoval from State 1		/2007	Catonsville	e, MD
atti	permit. Pag Department Important: I any Injury o			22. Name and Address of Facility	Damage 1	Hama Tara	
<u>m</u>	89118	100	state of autentic	Burgee-Henss-Seitz 3631 Falls Road B	altimore.	Maryland	21211
П			23a Part F. Enter the disease, or complications that caused the death. Do not e shock, or heart feiture. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
r l	Physician	i	immediate Cause (Final disease or condition	icoholoputh	X+tai	lvili	Oliset and Death
6	/Medical Examiner		resulting in death) Due to (or s a consequence of):	(
		Ŀ	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	10/1			
	nsit A d	mine	cause. Enter Underlying Cause (Disease or injury),
Ć,	exection and in and ial-tra	Examiner	that initiated events resulting in death) Last c				
8760	cate be executed obysician and the burial-transit	dical	d				
Õ	rtifica ng ph	Med	IF FEMALE:				
Box	ath ce tendi	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pripregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of del Month	livery Day Year
0	the all	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		l montai	54 , 154.
۵.	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	signe d be	d by	End. Stane Fund Dunu	_	1 □ Ye	s 2 No 3 P	robably 4. Únknown
CO	w req been shoul	lete	CACdio Mon North		24a. Was an	24b. Were au	utopsy findings available
Re	The la e has age 2	Completed	00,000	-+1	autopsy	prior to death?	completion of cause of
Vital	an: rtifical tor, p	Be C	25. Was case referred to medical	26. Place of Dea	1 Yes 2 ath (Check only one		22110
>	nysical nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ Yo	ient 3 DeA Other: 4 Nursing F	lome 5 Reside	nce 6 ☐Other (Spe	cify)
0	ng Pl		27. Man or of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	y Work?	28d. Describe how	w injury occurred	
sio	tendl eath. tor: A the fu	cati	2 Accident investigation	M 1 Yes 2 No	207 11 (0)		
Division or	or At offer d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could flot be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Ri State)	urai Houte Number,
_	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place	e, and due to the ca	use(s) and manner as	s stated.
	e Ho	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.	investigation, in my opinion, death occu	urred at the time, da	ate and place, and due	e to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
•	11			071600		1	9/2017
	1511		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	1 - 10	O E L	1 2000
	1-		31. Date filed (Month, Day, Year) 32/Registrar's Signature	J- 7600 N.M	101116	X TWI 1	JOHNIN (N)
	Sta Registi		IAN 1 1 2007 Lives B. A	parte			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8 30 PM **Physician** 200 t-LLA MAE JACKSON Januar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner -Conard + aun
If Under 1 Year | If Under 24 Hrs. ot Mari 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1□M 20F 230 34 26/8 Usual Residence of Decedent Yrs. Director 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Xington 10t. Zlo Code 10g. Citizen of What Country? 10e. Street and Number 20053

13. Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.))rive Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 NNo
If Yes, Give
Year or Dates: 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after near of Heelih and Mental Hygiene. ant: if item 27 is marked other than "natural; or item ury or other traumatic event, ITE Musilca Esach arry or other traumatic event, ITE Musilca Esach at 1 ☐ Never Married 2 ☐ Married 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel xciety touse helping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Johnny M. Simmons tannie M. Garrett ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lexington Park mD 80653 Wheeler Dr Connie M Granger **Laughter** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Importent: If ite any injury or ot page. 1 Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility Voughn Greene puneral Service Vocdlaun 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death 8728 Liberty Rd Mandall Soun MD Immediate Cause (Final disease or condition HOURS **Physician** POKIA resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS HERRA ON GESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Dav Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Ś 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 2 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 ☐ Yes 2)X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2K ER/Outpatient Certification: To 1 Yes 2 No 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b Time of 27. Manner of Death After 5 Pending investigation Natural 1 Tyes 2 No death. 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated ţ 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2007 MD D0062662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD TOWN POINT ESTURNAY 25500 RD T16712 LOCKOUT

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 2007

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** JR. NORMAN 6: 200 Januar /Medical City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NHOL N/A If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) If Unde 5. Social Security Number 7. Age (In yrs. last **Funeral** Months Days Hours **1€** M 2 □ F Yrs. 55 July 21 1951 MARYLAND Director 215-56-0465 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show ltem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1322 SHERWOOD AVENUE 21239 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: BLACK \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event than "na once." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MICHAEL WALKLEY 4yrs C.A.D.D. ENGINEER 12yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NORMAN F. JOYNER SR. ARLENE BARNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Sherwood AVe., Baltimore, Maryland 21239 Patricia D. Joyner/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY 01-13-07 BALTIMORE, MARYLAND 21. Signature of Fune al Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day moltingan falux disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitiated events resulting in death) Last Examiner physician and stransit hepati tailure Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical years Heraphs C cornosis use as been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Imonan 24a. Was an autopsy performed? 1∐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗌 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified RES-000 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, Mary land 2128 He 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7

2007

Physician Examiner certificate be executed P.O. Box 68760, Records, or Vital To the Hospital or Attending Physician: Division

Examiner and attending physician the as nse for detached the þ signed be has certificate this

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>ک</u>

Completed

Be

ည

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

/Medical

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral Medica

Physician/Medical 2 Completed Be P Certification:

Registrar

State

29a, Certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

00000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Drive Baihmore Md 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiere U U 1 - State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 5, 2007 9:00 P M **Physician** January BEVERLY FERTIG KABERNAGEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery County NATIONAL LUTHERAN HOME Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Apr. 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year) Min. **Funeral** Months Days Hours 1 ☐ M 2 🙀 F 1918 Pennsylvania 88 214-24-1111 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State or 28e-f show 1 ☐ Yes 2 ☑ No Rockville Montgomery County Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death wilt. Department of Health and Mental Hygiene. I have the protrant: If item 27 is marked other then "nature!', or iteme 23e or any injury or other traumatic event, the Medical Examinar must be anote. 20850 USA 9701 Viers Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. White Baltimore, Maryland 21215-0036 <u>۾</u> 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chief Clerk Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mabel Christiana Mever Earl Payne Fertig 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Charlcote Place, Baltimore, MD 21218 (P.R.)Emried Cole, Esq. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druid Ridge Cemetery 1/10/2007 Baltimore, Maryland 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. PIATEIN D. Lawson

6500 York Road, Baltimore, Maryland
21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

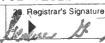
Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, awom Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke **Physician** /Medical Due to (or as a consequence of): **Examiner** nevier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to of as a consequence Physician/Medical Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 💆 No ō 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation filled in by the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funerei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) NATIONAL LUTHERAN HOME SHARON YANG, MD, 9701 Viers Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4,2001 /Medical 4b. City, Town, or Location of Death 4c. County of Dea 4a. Facility Name (If not institution, give street and number) TORE Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign Cauntry) If Under 24 Hrs. If Under 1 **Funeral** Days Hours Director 10d, Inside City Limits 10a. State 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo 21215-0036 Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working jife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Baltimore, Maryland Be and Mental P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rui *l*wife Pages 1 and 2 tment of Health ? 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Pa. 1. Enter the discusse, or complication shock or heart fail ye. List only one caus Immedian Cause (Final disease or condition resulting in death) hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. UEAR **Physician** /Medical True to (or as a consequence of): **Examiner** iabetes Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed SIOY burial-trai Due of (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 4 Donknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Medical Certification: To 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🗋 🗎 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 09 2007 7:50 A M Caroline Louise Lawrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Futurecare Old Court Randallstown Baltimore Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 16, 1920 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 217-05-8167 86 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Maryland Windsor Mill Be Completed by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21244 United States Of America 1 and 2 should be filed within 72 hours after death. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23, other traumatic event, the Medical Enaminal must <u>2924 Ridge Road</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leroy Eney Elsie Strahler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: if Itam 27 is Michael Lawrence (son) 2924 Ridge Road, Windsor Mill, MD 21244 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If I any injury or once. Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 01/12/07 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee hay Lemmer 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 110 20 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month jo Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 TYes accia o vas cular 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No a 1 Yes 2 No : After this certifical funeral director, p 25. Was case referred to examiner? nedical 26. Place of Death (Check only one) Other: 2 No Medical Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier c. License number 29d. Date signed (Month, Day, Year) D0020964 January 10, 2007 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pikesville, MD 21208 1100 Reisterstown Road Suite 202 Jerome H. Ginsberg, M.D. 31. Date liled (Month, Day, Year) 32. Registrar's Signature

State

Registrar

JAN 1

			1- State of Ma	ıryland		rtment of H		d Mental H	ygiene Reg. No.	2007	0045	9
	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of D		Year	3. Time of Death	_
0	/Medi Exami		LESTER 4a. Facility Name (If not institution, give street and number)	N		4b. City, Town, or	r Location of D	Dentary	1 09 4c.	County of Death	11:15 A	u
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. It	tim une	Balt-	MITE If Under 24	Hrs. 8. Date of B	irth	9 Rinth	N/A	
	Director		215-28-7180 1 M 2 F Usual Residence of Decedent	90	Yrs.	Months Days	Hours	05/18/	1916	Cou	place (State or Foreig ntry) PA	
	nyland show	_	10a. State 10b. County	10c. City	, Town or Lo						10d. Inside City Limit	s
	death with the Maryland ms 23a or 28a-f show	Funeral Director	MD BALTIMORE 10e. Street and Number		BAL	10f. Zip Code			10a Citi	zen of What Cou	1 ☐ Yes 2 🕅 N	0
	23a or	aiDi	3114 MARNAT ROAD			101. 219 0000	21208		rog. Oita	zen or what cou	USA	
10	b 22	Fune	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 □ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	'n	H	Vas Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 1	4. Race - Ameri Black, White		
\ 0036	72 hours after "natural", or ite idical Examina	5	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	WWI	I 1	☐ Yes 20X No	Specify:			Specify:	WHITE	
215-	within 72 ane.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	-)	(Give)	ent's Usual Occupa kind of work done o OO NOT use retired	during most of	working	16b. Kir	nd of Business/Ir	ndustry	
\$ t2	filed wil Hygien ther th		Elementary/Secondary (0-12) College (1-4or 5-	<u>5</u> +	PHYS	SICIAN	18 Mathada	Name (First, Middle	4	DICINE		
Lester Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natur any injury or other traumatic event, the Madical ance.	To Be	HARRY		LEBO)		ENNIE	э, маювп	Surname)	COBB	
Mar	od 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Type, Print) GLORIA ALLEN / NIECE					r Aural Aoute Numb GHLAND PA			Code)	
ore,	jes 1 and 2 of Health if item 27 i		20a. Method of Disposition 1 🗡 Burial 2 □ Cremation 3 □ Removal from State	20b. Pla	ace of Dispos	ition (Name of atory or other place	7	Date		cation - City or To	own, State	
Let Baltimore,	nit. Pages artment of ortant: if it injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	DRUI		E CEMETE		/10/2007		SVILLE,		_
Ba	permit. Departr Importa		Rotes James	\rightarrow			-	SOL LEVI WN ROAD -	NSON PIKE	& BROS. SVILLE.	, INC. MD 21208	
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death.	Do not ente	r the mode of dying	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical				ence of):	il he	marr	hage			5 days	
i	Examiner	9	Sequentially list conditions, b. Due to (or as a	conseque	ance of):							
J	be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· ·								
8760,	e be exersicien a	dicai Ex	resulting in death) Last Due to (or as a	conseque	ence of):							
9	eath certificate be ex ettending physicien for use as the burial	Medi	IF FEMALE:						-			
. Box	Physician: The law requires that the death certificathis certificete has been signed by the ettending praidirector, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of 1 Live birth 2	Fetal	death 3 □6	Ectopic pregnancy Other (specify)			2:	3d. Date of delive Month	ery Day Year	
P.0	that the de led by the e detached f		9 Unknown Part JI. Other significant conditions contributing to death but	not result	ting in the up	Herlying cause awa	on in Post I	220 Did	obassa us		ne cause of death?	
Division of Vital Records, P.O.	w requires tha been signed I should be det	ed by	Hypertension	1101103011			MINIFORT,			No 3 Prob		t
Reco	has be	Completed	•					24a. Was	psy	prior to co	psy findings available mpletion of cause of	•
ital	ysician: The lis certificete hadirector, page	Be Co	25. Was case referred to medical examiner?				26. Place of I	1 ☐ Yes		death? 1 🗌 Yes	2 No	4
of V	Physic rthis ce ral dire	ဍ	1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient		R/Outpatient	3□ DOA Othe	er: 4 🗌 Nursın	g Home 5 ☐ Resi	dence 6		v)	
ion	or Attending filer death. Director: After in by the funer	ation	1 XNatural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year)	Injury	28c. Injury Work	at ? ′es 2 ☐ No	28d. Describe	now injury	occurred		
Divis	if or Attending Patter death. Director: After to in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	y - At hom (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	l Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	-	29a. Certifier (Circus cut) and maintain and	my knowl	edge, death	occurred at the time	e, date and planting	ace, and due to the	cause(s) a	nd manner as st	ated.	
	To the within 2 To the complet	Medical	one) and manner state 29b. Signature and title of certifier	id.		29c. License		,		signed (Month,		
			Indy Huan	~		RES	5 - 00	0	Tanu	lan	9, 2007	
	20	,	30. Name and address of person who completed cause of dea	ith (Inem 2	3a) (Type, P	rint)	- L	f Bal	1. 2.3	J	1	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Degistrar	s Signatur	re	00>			1 ANC			
	, region			_8	100							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WALTER SAMUEL JANUARY LEVIN 2007 12:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Nonths | Days | Hours | Min. | 10/27/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Director 218-28-5977 75 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 □Yes 2√□No HARFORD FOREST HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 B WILLRICH CIRCLE 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married WHITE Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY AT LAW tem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental LOUIS LEVIN ZELDA LEVITT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 B WILLRICH CIRCLE - FOREST HILL, MD 21050 ELAINE LEVIN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or otl
once. BETH TFILOH CONG. 1 M Burial 2 □ Cremation 3 □ Removal from State 01/10/2007 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ISCHEMIC HEART DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical as attending use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy Por in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe certificate 1∐ Yes 2**K** No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 LOther (Specify) HOSPICE 1 ☐ Yes 2 X No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA after death. 27. Manner of Deatl 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

JANUARY

WALTER LEVIN

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23d per dyr 263 1-11-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Mary Paulding Murdoch Martin 9:35 AM January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Place Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 214-34-3129 1 ☐ M 2 💢 F 94 Yrs. February 8, 1912 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/AMaryland Baltimore Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th St. 21211 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XX No Specify: Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) museum director museum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Paulding Murdoch Rebecca Coke Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma M. Halpert/daughter 1 Blackwell Place Philadelphia, PA 19147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James Epis. Ch. Cem.Jan. 10,2007 Lothian, Maryland 22. Name and Address of Facility
Mitchell - Wiedefeld Funeral Home,
Mitchell - Wiedefeld Funeral Home,
MD 21 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) umorica 3 Weeks Due to (or as a consequence of): Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence off Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗷 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ٩ Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the use as t this After this funeral of I Director: A set in by the f death filled in within 24 hours e To the Funerel I

Funeral

Director

il Hygiene. I other than "natural", or iteme 23a or 28a-f ahow vent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 2, any Injury or other traumatic event, the Medical Examinar manages.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

the Maryland

State Registrar

Medical

29a. Certifier

J. Steller MM

29c. License number DO025662

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiliter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2007

Baltimore, MD

30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)

Gregory L. Walker, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAN 1 1 2007

333 N. Calvert St., #540 Registrar's Signature

		1 - For State Registrar	State of Maryl		ertificate of			Reg. No.	2007	00462
Physici		Decedent's Name (First, Middle, Last ANNA MARIA) MARTIN				2. Date of De Month	Day		3. Time of Death
/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De	January		2007 County of Death	9:30 p ^M
EXAMINI	ier	9500 Cissell Aven			Laurel	- Location of Bc	alli		oward	
Funeral		Social Security Number 6. Se	0 1 3	yrs. last birthday) If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th.	9. Birth	place (State or Foreign
Director		220 10 0000	^{™ 2} x ^F 78	Yrs.	Months Days	Hours Mi	sept.	22, 1	928 Ge	ntry) rmany
3		Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or L	ocation					104 1-14-02-11-2
sho	ō			aurel	.oodiion					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
28a-	Director	10e. Street and Number	deolge b L	aurer	10f. Zip Code			10a Citiz	en of What Cou	
3a or			t. 1		20707			U.S		itti y :
ms 2	Funeral	11. Marital Status	12. Was Decedent Ever i	n U.S. 13	Was Decedent of H	ispanic Origin?	(Specify Yes or No		4. Race - Ameri	can Indian,
or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔏 No If Yes, Give		1 ☐ Yes 2 ☒ No	an, Mexican, Pu Specify:	erto Hican, etc.)		Black, White,	etc.
uraľ, i Exa	d by	3 XWidowed 4 □ Divorced	Year or Dates:						^{Specify:} Wh:	
"nat edica	lete	15. Decedent's Edu (Specify only highest grad	ication le completed)	i (Giv	edent's Usual Occup e kind of work done o DO NOT use retired	durina most of w	vorking	16b. Kin	d of Business/Ir	dustry
than the M	Completed	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)		dent Mana	•		Apa	rtment 1	House
other ent, t	Be C	17. Father's Name (First, Middle, Last)	-				lame (First, Middle			
rked o	To B	Justus Aubel				Hermin	e Prieste	er		
s ma		19a. Informant's Name/Relationship (T)	pe. Print)	19b. Mai	ing Address (Street	and Number or	Rural Route Numb	er, City or	Town, State, Zij	c Code)
n 27 i	1 3	Jeanette Gavel /	daughter	9500	Cissell	Avenue	Laurel,	Mary	land 20	0723
if iter		20a. Method of Disposition 1XX urial 2 □ Cremation 3 □ F		 Place of Disp cemetery, cre 	osition (Name of ematory or other plac	ce)	Date	20c. Loc	ation - City or T	own, State
tant: Jury o		4 □ Donation 5 □ Other (Specify,		Union C			9/2007		tonsvil	le, MD
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	/ M0077	0	22. Name and Address Donaldson 313 Talbo	ss of Facility Funera tt Aven			aryland	20707
		23a. Part1. Enter the disease, ir comp shock, or heart failure. List only o	lications that caused the d ne cause on each line.	leath. Do not er	nter the mode of dyin	ig, such as card	iac or respiratory a	rrest,		Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	. Cerebral	Thromb	osis					Onset and Death Months
Medical caminer		resulting in death)	Due to (or as a con	sequence of):						
	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):						
Insit	Examin	cause. Enter Underlyin Cause (Disease or injury that initiated events								
physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a con-	sequence of):						
ysicia ne bui	edical		d					_		
0)		IF FEMALE:								
attending for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F		□Ectopic pregnancy	,		2:	3d. Date of deliv	
by the at tached fo	sici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)				Month	Day Year
ed by detacl	Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the	inderlying cause give	on in Part I	23e Did t	obacco us	o contributo to t	he cause of death?
ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	l by	Hypertension	The second second second	rosalang in the	andonying dadde give	on an equit.				ne cause of dealit? Dably 4 ⊠Unknown
s been signer should be	Completed	Cardiomyopathy					_			
certificate has t	du						- 24a. Was		24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
ificate or, pa		25. Was case referred to medical				00 DI (D	1□ Yes	2 X No	1 ☐ Yes	2 🔀 No
s cert directe	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	P □ FR/Outnatie	nt 3□ DOA Othe		eath <i>(Check only o</i> Home 5 Resi		V-Vou 10 1	Daughter'
h. After this funeral dii		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time			28d. Describe			Mesidence
ah. Mr Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORUT, Day Year	r) Injury		Yes 2 □ No				
er de irecto	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, si	treet, factory, office		28f. Location (S	Street and	Number or Rura	al Route Number,
ours ter dea leral Director filled in by the	Certification:									
Fune Fune tely fil		(Check only 2 Medical Exam	sician: To the best of my iner: On the basis of exan	knowledge, dea nination and/or i	th occurred at the tin nvestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the courred at the time.	cause(s) a	and manner as s place, and due t	tated. o the cause(s)
within 24 hours. fler dea'h. To the Funeral Director. After this certifio: completely filled in by the funeral director,	Medical	29b. Signature and title of certifier	and manner stated.		29c. License					
.≱ ≒ ⊗		b ////	- 11 PIAA D.	h					signed (Month,	
ιĎ	1	30 Name and address of norsen who	mpleted cause of doots (1 1 1 Tun-		13916		Jani	uary 8,	2007
10		30. Name and address of person who of William A. Warren,			eorge Str	eet La	aurel, Ma	ryla	nd 2070)7
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature			-,			
Registr	ar	JAN 1 1 200	7 196	M A	5000 8					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, ★

07-00269			ease Type	or Print in B	lack In	delible	Ink. E	nsure	e All Co	pies Are L	egibl	e.	
John Preston Mo		1- For State	State	of Maryland			of Heal		u ivienta	i Hygiene	Reg No	200	7 0046
Physicia Medical Examir	n/	Registrar 1. Decedent's Nam Sohn		moore,	5r					2. Date of D Month January	eath Day 9, 200	Year 17	3 Time of Death 2042 hrs
		4a. Facility Name (Northwest I	_	ve street and number	r)			own, or allstow	Location of D	eath		c. County of Death Baltimore Cou	
Funeral Director		5. Social Security I		Sex 7. A	ge (In yrs. Ia) If Undo Month	er 1 Year s Days		Min)	Birth(MM	1/DD/YYYY) 9. 8iri Foreig Coi	
any	ŀ	Usual Residence of 10a. State	10b. County			Town or Lo							10d. Inside City Limits
	ğ	mD	USA		, K	and	Allst				10a Cu	tizen of What Cour	1 Yes 2 No
the Man	Director	9104 Ve	^	7			ì	2113	33			USA	n y :
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "matural", or items 23a or 28a-f show matie event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marri		1 Yes 2			If Yes, specif	y Cubar	n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri White, etc.	
urs afte	2	3 Widowed 15. Decedent's E		d If Yes, Give Year or Dates: only highest grade co	mpleted)	16a. Dece		Occupat	tion (Give kin	d of work done	16b.	Specify: B	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner.	Completed	Elementary/Sec	condary (0-12)	College (1-4 or	r 5+)		g most of wor $\lambda S \mathcal{D}$			e retired)	T	ranspor	tation
15-0036 filed within 7 I Hygiene ed other than t, the Medica		17. Father's Name			60			Ĩ		Name (First, Middle		,	
2121; ould be fill I Mental E s marked ic event,	To Be	19a. Informant's N	ame/Relationship (_		et and Numbe	er or Rural Route N	lumber, (City or Town, State	
MD and 2 sho salth and 2 sem 27 is ranmati		John Pres		e, Sr. CF			1 Vego			Kandal	Is ta	Location - City or	21133
altimore, rmit. Pages I an ppartment of Hea pportant: If iter inry or other tra		1 Burial 2		Removal from S	State	crematory o	r other place)		ian. 16, 2		altimore,	
Baltir	j	21. Signature of Fi	uneral Service Lice	ensee	1,	2	2. Name and	Address	s of Faculity	eene Fu	ner	al Servi	us
Physician		23a Part I Enter t	the disease, or com	nplications that cause each line. Hyper	ed the death.	Do not ent	er the mode	of dying,	such as card	Trike diac or respiratory scular dise	arrest, sh	to, IND	Approximate Interval Between Onset and
/Medical Examiner	1 6	Immediate Cause or condition result	(Final disease	4-1	e bronc	hopneu				Scarci disc		2330CIdeed	Death
B. Barren St. Lag.	L	Sequentially list of	onditions,	o									
	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated counts resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):											
vecuted ransit	Ě	events resulting in		d.	isequence o	T).							
0, s be exe sician a	edical	X UNPENDE	D [#23a,PII			54 , 2/2	1/07	TT			Od Data of dall and	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be ex thir 24 hours after death the this certificate has been signed by the attending physician upletely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medi	IF FEMALE: 23b. Was deceden past 12 month			ome of preg	2	Fetal death Other (Spe		Ectopic p	regnancy		3d. Date of deliver	y Day Year
O. B nat the d ed by the		· ·		s contributing to dea		-	he underlying	g cause	given in Part				the cause of death?
ds, P. equires the seen signed and be d	ted by	End-st	age renal d	lisease; sei:	zure di	sorder				1			oably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after cleath al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	Completed						_				topsy rformed? s 2	death?	completion of cause of
tal R cian: T certific ector, p	Bec	25. Was case refe examiner?	erred to medical	Hospital:		1		_	Othor	heck only one)	7		
1 of Vi Jing Physi After this	οT :Γ	1 Yes 27. Manner of Dea	2 No_	28a. Date of Ir (Month, Day	tient 2 🗸	28b. Time		28c. Inju	ury at Work?	Nursing Home 5		dence 6 Othe	r
Sion Attendii death sctor: A	catio	1 X Natural 2 Accident	5 Pending Investiga	ation	·		atanat faatan		Yes 2 N		n /Ctroot	and Number of D	ural Route Number, City
Divisior septial or Attenc hours after death meral Director:	Certification:	3 Suicide 4 Homicide	6 Could no determin		injury - At n	ome, rarm,	street, factor	y, omce i	building, etc.		n, State)	and Number of Ro	arai Route Number, City
Divisior on the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2		ician: To the best of ier:On the basis of exand manner state	xamınation a								
Ø	Me	29b. Signature an		, mus			29		se number			Date signed (Monuary 10, 200	
		30. Name and add		o completed cause o	f death (Iten	n 23a)					١٠٠		
1,02	6 6	Ling Li, MI		Medical Examin			treet, Balt	imore,	MD 2120	1			
Si Regis	tate trai		AN 1 1 20	007 32 Regist	trar's Signat	19	aski .						

			1 - For State Registrar	State of Ma	ryland / D	epartm		ealth a	and Me	ental Hyg	_	07	00464
			Decedent's Name (First, Middle, Last	st)				-		2. Date of Deat	h		3. Time of Death
	Physici /Medic		Matilda E. Meyer							Jan. 6	, ^{Day} 2007	Year	1:25 p ^M
ì	Examir		4a. Facility Name (If not institution, give		_		City, Town, or		of Death	-		ty of Death	
		٠	Glen Meadows Ret				len Arr					imore	
	Funeral Director		5. Social Security Number 6. S 213-28-6362 Usual Residence of Decedent		(In yrs. last birth	Mon	nder 1 Year oths Days	If Under Hours	Min.	8. Date of Birth Month, Day 3/09/19	06 6	9. Birth Cou Mary	place (State or Foreign ntry) Tand
	land ow		10a. State 10b. County		10c. City, Town	or Location)					T	10d. Inside City Limits
	Many F-f sh	ţ	MD Baltimor	^ e	Glen A	rm							1 ☐ Yes 2 🛣 No
	th the	lrec	10e. Street and Number			10f	f. Zip Code			1	0g. Citizen o		ntry?
	23a (1811)	al	11630 Glen Arm I	?d.			21057				US		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, it a Medical Exspirier must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:			Decedent of His specify Cubar es 2 🛣 No	spanic Ori n, Mexican Specify:		cify Yes or No- lican, etc.)	B	ace - Ameri ack, White, ify: Whi	, etc.
2-0	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. I	Decedent's	Usual Occupa of work done do OT use retired)	ition	t of workin	0	16b. Kind of	Business/Ir	ndustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			l III	t of working	i			
2	led w lygier her th		9		Pia	no te		10 14-45-			Music		
and	I be fi	Be	17. Father's Name (First, Middle, Last) John Robert Knac							(First, Middle, M th Voel		ime)	
2	12 should be filed within " n and Mental Hygiene. F is marked other than " reumatic event, I're Med	2	19a. Informant's Name/Relationship		19b.	Mailing Add	iress (Street a			Route Number		n. State. Zii	n Code)
	and 2 sealth ar in 27 is		Mr. Ronald R. Meyer /				epid Ro			more, M			,
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra 2009.		20a. Method of Disposition 1		20b. Place of cometery Parkwo	Disposition c, crematory Od Ce	(Name of or other place metery) 1	./10/2		20c. Location Baltim		
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer	isee kimberly [avidson >>		and Address		•		5 Harf timore		
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	the death. Do no	ot enter the	mode of dying	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of	f):							1
		-	Sequentially list conditions,	b. Due to (or as a	a consequence of	n:							
19	uted I Insit	ul m	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			-,-						1	
ď,	exection and ial-tra	Examiner	resulting in death) Last	C. Due to (or as a	a consequence of	f):							
760,	ite be iysicia ne bur	cal		d									
89	ing ph	Med	IF FEMALE:										
Вох	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transitian.	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		oic pregnancy or (specify)					ate of deliv	ery Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□Unknown									
S, P	signed be det		Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlyi	ing cause give	n in Part I.			1/		he cause of death?
Records,	w require	ted	OD C							1 ☐ Ye	s 2 No	3 🗌 Prol	bably 4 Unknown
ecc	law r las be	Completed by	Odlegorozus							24a. Was ar autops	24b	. Were auto	opsy findings available impletion of cause of
=======================================	cate h	Con								perform	ned?	death?	2 No
of Vital	sicien: The law s certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Othe	- 1/		(Check only on			
	Phys r this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Mannual of Death	1 L Inpatie	nt 2 ER/Out		DOA	4 Mu		e 5 ☐ Reside			fy)
on	ding th: After	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) In	jury M	28c. Injury Work 1 🗆 Y	?` ′es 2 □ l			,-,, 0000		
Division	Attendi r death. sctor: A by the fu	ifica	3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At home, fan	m, street, fa	ictory, office		21	Bf. Location (St.	reet and Num	ber or Rura	al Route Number,
ā	s afte	Certification:	4 Homicide	building, etc	. (Spacity)					City or Town	, 3(4(8)		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: Atter this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysicien: To the best on niner: On the basis of and manner sta	examination and	death occu /or investiga	ation, in my op	e, date an inion, dea	d place, ar th occurre	nd due to the ca d at the time, da	use(s) and nate and place	nanner as s , and due to	stated. o the cause(s)
	With To t	M	29b. Signature and title of certifier	your			130L			29	Date sign	ed (Month,	Day, Year) 2007
•	3		30. Name and address of person who	completed cause of de	eath (Item 23a) (1	Type, Print)	4/Tima	RF		1021			
			31. Date filed (Month, Day, Year)	V UMITTOC	r's Signature	1)	101/110	7.0		11 21	J. 7		
	Sta Regist		Date lileu (Month, Day, 1ear)	32. Registra	lo logiature	1.	<i>y</i> .						
DHI	MH 17 Rev 1/2	100	JAN 1 1 2	007	a for	CISPAR.	1						
				_	ORIG	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Amend #19a Per FH G863 de Amend #19a Per FH G863		Reg. N	. 200	7 0046		
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Marcus Kieth McDowell		ate of Death onth Day nuary 8, 20	/ Year	3 Time of Death 1951 hrs		
			Location of Death		4c. County of Death			
		Johns Hopkins Bayview Medical Center Baltimore	Train and Table		N/A			
Funeral Director		214-29-2454 1X M 2 F 16 Yrs Months Day:	Months Days Hours Min. OF 10			Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary land		
any	ł	Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location		-		10d Inside City Limits		
and F show	ō	Alabama Madison Madison				1 Yes 2 X No		
D 21215-0036 should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland fis marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	Dire	10e Street and Number 224 De jan Road 10f Zip Code 35758		10g C	U.S.A.	try?		
ath wit items 2	Funeral		spanic Origin? (Specify ` n, Mexican, Puerto Rican		14. Race - Americ White, etc.	an Indian, 8lack,		
after de al", or ner mu	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced fry Bates: 1 Yes 2 X No 1 Yes 2 X No	specify:		Specify: Blac	:k		
hours a natura Exami	ed b	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupat		one 16b	. Kind of Business/li	ndustry		
36 hin 72 e. than "	To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Student			Dependent			
21215-0036 uld be filed within 72 hours is Mental Hygiene, marked other than "natura		17. Father's Name (First, Middle, Last) Anthony McDowell	18 Mother's Name (First Darlene V		en Surname)			
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental ant: If item 27 is marked or other traumatic event,		19a. Informant's Name/Relationship (Type, Print) Darlene Belvin - Daughter Mother 19b. Mailing Address (Stree 224 Dejan Road	Madison, Al	L 35758				
ore, ME es I and 2 s of Health ar If item 27 ther traums		20a. Method of Disposition 20b. Place of Disposition (Name of certain State) 8urial 2 K Cremation 3 Removal from State			c. Location - City or			
Baltimore, permit Pages Lar Department of Hes Important: If ite injury or other it	,	4 Donation 5 Other Specify: Hilltop Service Corpo 21. Signature of Funeral Servige Licensee A 22. Name and Address			Towson, Mary Ford Road	Tand		
Ba perm Depa Impo injur		Chales & Mines D. Leonard J.			e, MD 21214			
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Guns bot Wounds						
Examiner	Medical xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
		Sequentially list conditions, b						
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated						
ke a	Examiner	events resulting in death) Last Due to (or as a consequence of): d.						
e be executed ssician and burial - transit	Medical	UNPENDED AMENDED						
760, ficate be g physicia the buria	≥	IF FEMALE: 23c. If yes, outcome of pregnancy		12	23d. Date of delivery			
Box 68's death certiff the attending of for use as:	/sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy		Month D	ay Year		
Bo) he deatl	Physi	1 Yes 2 No 9 Unknown 9 Unknown	D [7	Did to be a				
, P.O.	ゑ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.		No 3 Prob	ably 4 Unknown		
ords, w require s been sig	eted		72	24a Wasan		opsy findings available		
ecol he law ite has l	Completed			autopsy performed Yes 2		ompletion of cause of		
Ital Recirian: The certificate	Be Cc		e of Death (Check only o					
f Vit Physic er this c	ဥ	1 Ves 2 No Inpatient 2 V ER/Outpatient 3 DOA	Other Nursing Hon	ne 5 Resi	dence 6 Other			
Division of Vital Records, rat or Attending Physician: The law require and rather this certificate has been siled in by the funeral director, page 2 should b	ertification:	1 Natural 5 Pending FOUND: FOUND: 1		ect shot	пјату осситеа			
ViSic or Atte fler dea Directo	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office to			t and Number or Ru	al Route Number, City		
Division Bospital or Attenc Abours after death Funeral Director:	Cert	4 V Homicide determined (Specify) Street 5100 Blk Harford Rd, Baltimore, MD						
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be excouted within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (one) Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (one) Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)						
To To	Me	and manner stated 29b. Signature and title of certifier 29c. Licens	se number	29	d Date signed (Mor	th, Day, Year)		
		Out ?	M.E.	Já	anuary 9, 2007			
4		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner	ore, MD 21201					
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regis	trar	JAN 1 1 2007 Beaut 13 Februar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** 0345 AM MCALLIST MNUARY 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 01 20 71 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Days Hours Min. MD 35 Director 215-78-8766 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Randallstown Baltimore 1 ☐ Yes 2X No Director MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21133 U.S.A. 9109 Liberty Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 盆 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Teacher's Assistance llth grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Oliver James McAllister Sr. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3016 Rayner Ave, Baltimore, Md Dale McAllister-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 1/10/07 Baltimore, Md 22. Name and Address of Facility arch F/H West 300 Wabash Ave, 21. Signature of Funeral Service Licensee Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASCVID /Medical Due to (or as a consequence of): **Examiner** on Hemodiaty Sis Sequentially list conditions, if any, leading to link educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cynsequence off Physician/Medical Examiner burial-transit physician s the burial BACTERWIL as IF FEMALE: nse If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 Probably 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death Date of Injury 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 24 hours after death. 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier (Check only one) 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Kandallstown MD

son who completed cause of death (Item 23a) (Type, Print) Old of Ed.

32. Registrar's Signature

29d. Date signed (Month, Dav. Year)

2007

		Please	Type or Print in E						_	ible.	
	1	For State Registrar	Contificate of Dooth							00467	
Physician		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day LILLIAN EDNA MYERS JANUARY 8;								Year OO7	3. Time of Death 9:25 P. M
/Medica Examine		LILLIAN EDNA MYERS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo						UNIONICI		y of Death	
- Adminic		STELLA MARIS HOSPICE			TIMONIUM				LTIMORE		
Funeral Director		5. Social Security Number 6. S 215-24-6557	ex 7. Age (In yrs.	last birthd Yrs	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	^(ear)	Cou	place (State or Foreign intry) YLAND
and www.	- 1-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town o	r Location						10d. Inside City Limits
Maryli fled at	5	FLORIDA SARASO	TA V	ENICE	Œ						1 □Yes 2 🕅 No
th the or 28a e noth	Director	10e. Street and Number				p Code		10	g. Citizen of	What Cou	ıntry?
23a c	<u>a</u>	540 CERVINA DRIV				3429			USA		
items	Funeral	 Marital Status Never Married 2 Married 	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	.S. 1	13. Was Dece If Yes, spe	edent of H ecify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - Amen ack, White	ican Indian, , etc.
urs a al', o	≥	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 No Specify:			Specif		fy: WHITE		
"natu	erec	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	(G	ecedent's Usu Rive kind of wife. DO NOT u	ork done	durina most of work	ing 1	6b. Kind of E	3usiness/Ir	ndustry
within iene. than	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)		AGENT	ise remed	1)		TRAVE	L AGE	ENCY
e filed other ent, t	9 9	17. Father's Name (First, Middle, Last,)	J			18. Mother's Name	e (First, Middle, M	aiden Surna	me)	
Menta Menta arked atic ev	0	GEORGE P. BELLOS GLADYS MARI			MARIE CH	E CHARLTON					
n and ls short ls mark		19a. Informant's Name/Relationship (Ι.	3	,	and Number or Rur	·	,		
1 and Healtl em 27	-	WALTHER M. MYERS/HUSBAND 540 CERVINA DRIVE NORTH VENICE, FL 34292 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State									
ages ent of nt: If It		1 A Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	VALLEY MEM. 1/13/2007 COCKEYSVILLE, MD DENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.								
permit. F Departm Importar any Injur	ŀ	21. Signature of Funeral Service Life		GA	22. Name a	nd Addre	ss of Facility TH	E JOHNSON	I FUNE	RAL F	HOME, P.A.
88 = 8		17. Tleaf	Oloner		8521 1	LOCH	RAVEN BL	VD. TOWS	SON, M	D 21	1286
		shock or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death			
Physician /Medical											
Examiner			Due to (or as a consequence or).								
xecuted and II-transit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauce (Disease or hijery that initiated events	sequence of):								
9 ⊏ 9	ш	resulting in death) Last C. Due to (or as a consequence of the conse			quence of):						
ate be the physici the bu	lica		d								
The law requires that the death certificate be enter the law requires that the death certificate be entered in the has been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)				23d. Date of delivery Month Day Year				
s that ned by e deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
w requires been sign should be	ed by	1 Yes 2 No 3 Probably 4 Unknown									
The law recate has be page 2 sho	Completed						24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?				
	0	1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)							2 110		
hysic this ce	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	 		OA		ome 5 Reside	nce 6 X IO	ther (Spec	city) HOSPICE
ding Ph h. After th funeral	ü	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Tin Inju		28c. Inju Wor	ryat rk?]Yes 2∐No	28d. Describe ho	w injury occi	urred	
or Attenc	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e Place of injuny - At h				Ties Z No	28f. Location (Str City or Town		nber or Ru	ıral Route Number,
= = = 1											
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.		2	9c. Licens	se number	29	d. Date sigr	ned (Monti	h, Day, Year)
F > F 0	- 1		/				-	I		101	

State Registrar DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

JAN 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar's Signature

107

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:50 p M 7, 2007 January RICHARD OWENS SR. JOHN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD CO EDGEWOOD 1716 JUDYWAY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 1**∑** M 2□ F MARYLAND Yrs 76 Jan 13 1930 Director 218-26-4662 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State r than "natural", or items 23a or 28e-i show the Modical Evantiner must be notified at 1 ☐ Yes 2 No **EDGEWOOD** HARFORD CO MARYLAND Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21040 1716 JUDYWAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 [Yes 2] No 11. Marital Slatus filed within 72 hours after 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 Specify: BTACK þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HARFORD CO PUBLIC al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SCHOOLS CUSTODIAN 4th grade nd 2 should be filed alth and Mental Hygis 27 is marked other in treumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any injury or other treumatic ever once. AMELIA JACKSON MALCOM OWENS ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1716 Judyway, Edgewood, Maryland 21040 Louetta M. Owens/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State DARLINGTON, MARYLAND BERKLEY CEMETERY 01-12-07 4 □ Donation 5 □ Other (Specify) 21. Signal e of Funer Service Licenses 22. Name and Address of Faculty
WM C BROWN COMMUNITY FUNERAL HOME HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Morale Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) D year Preru Discorre coronay **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to untre-liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 28 No 4 Pregnant at time of death 5 Other (specify) _ Records, P.O. 9 Unknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probebly 4 Unknown emphy sema. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 26. Place of Death | Check only one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 00 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident or Attencater death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Discompletely filled in Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number S. Rogeray. DEFE 200 C January 915, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beloir 602, S.Atwood PJ, #106, s. Rongural. mp. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 JAN 1 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Operation of Death

		For State Registrer 1. Decedent's Name (First, Middle, Last)			rtment of F tificate of		2. Date of De	Reg. No.		3. Time of Death
Physicia /Medic		Douglas . B.	DXFORD				Month	Day 4	Year 2007	6:00 P
Examin	er	4a. Facility Name (If not institution, give s WRLY MMNUAL 5. Social Security Number 6. Sex	CONTER	yrs. last birthday)	_	LOCATION OF Deat	8. Date of Bir	th	unty of Death	lace (State or Fore
Funeral Director			M 2□F 75		Months Days	Hours Min.		y, Year)	Cour	Ington, D
ed at	or	10a. State 10b. County	10c.	City, Town or Loc					1	0d. Inside City Lin
or 28a- be notif	Direct	Maryland 10e. Street and Number		Daltimo	10f. Zip Code	_			of What Cour	itry?
a hygiene. dother then "naturel", or lieme 23e or 28e-f show event, the Modical Extroiner must be notified at	by Funeral Directo	4800 Seaton Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 TT 103 F 110	340-	2121 Vas Decedent of H Yes, specify Cuba ☐ Yes 2☑ No		Specify Yes or No to Rican, etc.)	14.	JSA Race - Americ Black, White, ecify: Wh	
a hygiene. I other then "nature vent, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done O NOT use retired	during most of wa	rking		Improv	
	To Be C	17. Father's Name (First, Middle, Last) Roland E. Oxford					me (First, Middle,	Maiden Sui		
them 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type Kerry Dillsworth -			g Address (Street	and Number or R	ural Route Numbe	er, City or To	wn, State, Zip	Code)
0	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	b. Place of Dispos	sition (Name of atory or other place	ce)	Date	20c. Locati	on - City or To	wn, State
importent: It any injury o		21. Signature of Funeral Service License	4	1 22.	Name and Addre	ss of Facility		4739	Baltim	ore Ave.
Medical and physicien and street is the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. E.i.e. Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	isequence of):						Onset and Death
by the ettending platached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 I I 4 Pregnant at time 9 Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)	1		23d	Date of delive	ery Day Year
pe de	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause giv	ren in Part I.	23e. Did t	/		ne cause of death abiy 4 []Unkno
his certificete has been sig I director, page 2 should b	Completed						1 ☐ Yes	osy ormed? 2 No	prior to con death?	psy findings avail inpletion of cause 2 No
After ti funera	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of leath 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 X Inpatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (Sp.	At home, farm, stre	28c, Injur Wor M 1	er: 4 🗆 Nursing l	ath Check only of dome 5 Resident 28d. Describe 1 28f. Location (: City or To:	dence 6 how injury or	curred	r) I Route Number,
To the Funeral Director: completely filled in by the	Medicai Ce	22. Certifier (Check only one) 2 Medical Examin	ician: To the best of my ter: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the two	ne, date and place pinion, death occ	s, and due to the urred at the time,	cause(s) and date and pla	I manner as et ce, and due to	atol, the cause(s)
To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)

07-00152 Dominique Reenessa Pascall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
	F	For State Certificate of Death			g. No. 200	7 00471		
Physician Medical Examine	er	1. Decedent's Name (First, Middle,Last) Dominique R. Pascall 4a. Facility Name (if not institution, give street and number) 4b. City, Town	or Location of Death	Date of Death Month January 6,	Day Year	3. Time of Death 0840 hrs		
		221 International Circle #153 Cockeys			Baltimore Cou			
Funeral Director	2	5. Social Security Number 214-41-2185 Age (In yrs. last birthday) If Under 1	Dave Hours Min	8. Date of Birtl	(MM/DD/YYYY) 9. Birth Foreig Cou			
any	-	10a State 10b. County 10c. City, Town or Location				10d Inside City Limits		
land f show once.		Md Baltimore Windsor Mill				1 Yes 2 XNo		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Depa ment of Health and Mental Hyggiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury rother traumatic event, the Medical Examiner must be notified at once.)lrec	10e. Street and Number 10f. Zip Cod 2124 Yennar Lane # 2B 2124		10	g. Citizen of What Cour	itry?		
ms 23a		11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Spe		14. Race - Americ	can Indian, Black,		
or death	Funeral	1 Yes 2 X No	ban, Mexican, Puerto R	ican, etc.)		n-America		
urs afte	2	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X 15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occ		rk done	Specify 16b. Kind of Business/li	ndustry		
6 172 ho cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retire	d)	Sudbrook			
-003 Lwithir giene Brer the	E -	7th Student 7. Father's Name (First, Middle, Last)	Ident School 18 Mother's Name (First, Middle, Maiden Surname)					
215. 215. be filed intal Hy rked of ent, th	a D	Sheroi Pascall	Wendy	dv M. Phillip				
D 21 should md Me 'is man		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	treet and Number or Ru	ral Route Num	ber, City or Town, State, Vindsor Mi	Zip Code 21244		
and 2. sealth a tealth a tem 27 traum	- 1-	20a. Method of Disposition 20b. Place of Disposition (Name of		Date V	20c. Location - City or			
nore		1 ABurial 2 Cremation 3 Removal Yrom State crematory or other place) 4 Donation 5 Other Specify King Mem. Pa:	rk 01 - 1	2-07	Woodlawn	, MD		
altir		21. Signature of Funeral Service Licensee 22. Name and Add	ress of Facility Wy1	ie F/I	II.A. of	Dalto. Co		
3 2	1	ANCON M 9200 Li 23a Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dy				, MD 21133 Approximate Interval		
Physician /Medical	7	failure. List only one cause on each line. Immediate Cause (Final disease a. Acute intracerebral hemorrhage	ing, odor do odrado or i	cophatory and	ot, or local	Between Onset and Death		
Examiner		or condition resulting in death) Due to (or as a consequence of):						
	_	Sequentially list conditions, if any, leading to immediate b. Venous malformation Due to (or as a consequence of).						
	ΞI	cause Enter Underlying Cause (Disease or injury that initiated c.			<u> </u>			
		events resulting in death) Last Due to (or as a consequence of): d d						
. = = G	geal	X UNPENDED AMENDED 4,27, perME, g865, 3/1/07 3	Т					
68760, certificate be nding physicise as the buri	n/Me	IF FEMALE: 23c If yes, outcome of pregnancy 3b. Was decedent pregnant in the	3 Ectopic pregnan	cv	23d. Date of delivery Month	ay Year		
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	sıcıan/Medi	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		-,				
that the decrete by the a	إ≥	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I	23e. Did tol	bacco use contribute to	the cause of death?		
P.O. ires that t	े			1 Yes	2 No 3 Prob	ably 4 Unknown		
of Vital Records, ug Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			24a Was a autops		topsy findings available ompletion of cause of		
tal Reco	Ę			perform 1 Y Yes 2		s 2 No		
ician: s certifi rector.	Be	examiner?	Other Nursing					
n of Vi	<u>۹</u>	1 Ves 2 No Institute 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c.			Residence 6 🗸 Other ow injury occurred	Scene		
ion rendin eath tor: A the fur	atio	1 X Natural 5 Pending (Month, Day, Year) 1 2 Accident Investigation 1						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici principle in by the funeral director, page 2 should be deached for use as the buring of the state of the purification o	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office (Specify)	ce building, etc 2	28f Location (S or Town, St	treet and Number or Rulate)	ral Route Number, City		
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated						
8/12	Ž		ense number		29d Date signed (Mor	nth, Day, Year)		
d'h		O. Name and address of person who completed cause of death (Item 23a)	C.M.E.		January 7, 2007			
1.03		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimor	e, MD 21201					
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
DHMH 17 Rev 1/200	_	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2007 ŏš 22:40 Peterson Sr Levi 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3409 Cedardale Road Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav 8. Date of Birth (Month, Day, Year) 09 01 25 9. Birthplace (State or Foreign Days Months Hours Min. **X**□M 2□F 81 NC 246-24-6661 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3409 Cedardale Road 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 💆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Corp. 12th grade Fork Lift Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen Peterson Emma Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Fields-Daughter 6442 Pound Apple Court, Columbia, Md 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1/17/07 owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pel 11. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death HEART DISEASE Immediate Cause (Final disease or condition resulting in death) NSIVE Due to (or as a consequence of): HYPERTEXICION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DSTATE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 1 Tyes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Department o important: If any injury or once.

Physician

*/Medical

Examiner

Director

Funeral

à

Completed

Be ဂ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

the. attending pl

Examine Physician/Medical ò Completed Be 27. Manner of Death

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed after death 24 hours a within 2

Division or Vital Records, P.O. Box 68760,

2+1

Registrar

31. Date filed (Month, Day, Year) State

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

45244

1 TYes 2 □ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) REENE ST, BALTIMOLE, CHANDRAKALA

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Physician WILLIAM EUGENE PAESCH, SR. 2007 2:15 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days 216-20-7193 Director 7/19/1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow other traumatic avant, the Modical Exeminar must be notified at MD BALTIMORE TOWSON 1 Yes 2 No **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 FELDBROOK ROAD 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4or 5+) CORP. 12TH GRADE ELECTRICAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN PAESCH CLARA GARRETSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 Is any Injury or other trai PATRICIA PAESCH/WIFE 1603 FELDBROOK ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State MOST HOLY REDEEMER
CEMETERY 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 1/12/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Weeks disease or condition resulting in death) /Medical Examiner 4SPHASIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ned by the attending physicien and detached for use as the burial-transit Irokes Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be ive 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\times \) Yes \(2 \times \) No 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified ed cause of death (Item 23a) (Type, Print) 1070 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			For State Registrar		State	of Maryla		artmen ertificat			and M	-	giene Reg. No.	007	004	73
	n.		1. Decedent's Nan	ne (First, Middle,	Last)							2. Date of De Month	ath Day	Yea	3. Time of De	ath
	Physici /Medio		John	Tate	2		Pres	ton	III			January		2007		'A ^M
	Examir		4a. Facility Name			imber)				Location of	f Death		4c. C	County of De	ath	
				gate Dri					n Bu						cunde1	
	Funeral		5. Social Security		.Sex 12XM 2□ F		s. last birthdaj 27. Yrs.	/) If Under Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. B	irthplace (State or Fo	oreign
	Director		425-30- Usual Residence			8	34 Yrs.					Feb. 5	, 192	22	RI	
	and		10a. State	10b. County		10c. (City, Town or I	ocation							10d. Inside City L	_imits
	Marylan f show	ō	MD	Anne Ai	runde 1		Glen B	urnie							1 Tes 2	√No
	the Mi	Director	10e. Street and Nu						Code				10g. Citiz	en of What (Country?	
	3a or	0	172 Marg	ate Driv	7.P			1	1060				-	S.A.	,	
	s after death with the Maryla , or iteme 23a or 28a-f shov raminer must be notified at	Funeral	11. Marital Status	,	12. Was Dec	edent Ever in	U.S. 13			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		4. Race - An	nencan Indian,	
9	or ite		1 Never Mar	ried 2 Marne	Armed F	2 🗆 No					, Puerto I	Rican, etc.)		Black, Wh		
93	rai',	d by	3 🕅 Widowed	4 Divorced	If Yes, G Year or I	Dates:		1 🗆 Yes	ZILINO	Specify:			3	Specify: W	nite	
5-0	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-f ahow thit, the Medical Examinar must be notified at	Completed	(Spe	15. Decedent's cify only highest)	16a. Dec	edent's Usus e kind of wo DO NOT us	al Occupa	ation furing most	of workir	ng	16b. Kin	d of Busines	s/Industry	
2	hen.	id m	Elementary/Sec	ondary (0-12)	College	(1-4or 5+)							0 -	. 1 0		
2	filed v Hygie ther t		17. Father's Name	/First Middle La	act)		Sys	tems A	Analy		de Nama	/Circl Adiddle			ecurity	
anc	ed in p	Be										(First, Middle,		,		
Ĕ	2 should be to and Mental I is marked of raumatic eve	ို	John Tat				405 145		(0)			garet			7. 0.11	
Z Nai	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Mrs. Kar			tor						Route Numble Burnie			Zip Code)	
e, I	Heall the		20a. Method of Dis		, Daugn							ate	-		r Town, State	
Baltimore, Maryland 21215-0036	permit. Pages Department of H Importent: if ite any injury or of		1XXXBurial 2	☐Cremation 3		State	. Place of Disp cemetery, cr			ł	Jan	12,				
草	rtmer rtent rjury		4 ☐ Donation 21. Signature of F	5 Other (Spe		I M	larylan				200		Crow	msvil	le, MD.	
Ba	permit. Depertr Importe any inju		21. Signature of F	I II I	2011500	110	1	22. Name ar	10 Addres	s or Facility	Sir	igleton	Fune	eral H	ome, P.A.	
			23a. Part1. Emer	the disease or or	amplications that							Glen Bu		MD 21	Approximate	
8760, ^C	Physician /Medical Examiner ponial-transit	al Examiner	Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to i cause. Enter Und Cause (Disease o that initiated event resulting in death)	onditions, mmediate erlying r injury is	a. Due to	(or as a conse	equence of)(/asc)v	Y	Ac Dis-	eid	end		Interval Betwee	
P.O. Box 6	that the death certificate ed by the attending phy detached for use as the	Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknow!	2 months?	1⊡Live 4⊡Preg 9⊡Unkr		etal death 3 f death 5	□Ectopic pi □ Other (sp	pecify)	n in Part I.		23e. Did t		d. Date of d Month	elivery Day Yea	/
ds	w requires been sign should be	d by	1	avkin	SAN 1	5	Seas.	2					/es 2 🗆		Probably 4 Stonki	
Ö	v req beer shou	Completed								-		24a. Was		24h Mara	votana votin din na more	حاطما
Bě	The lar	립							-			autor		prior to	autopsy findings ava completion of caus	e of
a	icien: Th certificate ector, pag	ပိ	25. Was case refe								1000000	1□ Yes	-	1 🗆 Ye		
=	sicie certi	00	examiner?		Hospital:	Inpatient 2	C	aCl DC	Othe			Check only o		C 0		_
of	tending Physicien: leath. tor: After this certific the funeral director,	٠. ت	27. Manner of Dea			of Injury oth, Day Year)	☐ ER/Outpation 28b. Time		28c. Injury Work	at Nur		ne 5 Affesio			ecity)	
o	th. th: After funer	ţ	1 Natural 2 ☐ Accident	5 Pending investiga		nth, Day Year)	Injury	м		? /es 2 □ N						
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fi	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad 288. Plac	e of Injury - At ling, etc. (Spec	home, farm, s	treet, factory	, office		2	8f. Location (S City or Tox	Street and vn. State)	Number or I	Rural Route Number	;
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		00 0 1/1		D											
	Hose 24 ho Fund fely f	edicai	29a. Certifier (Check only one)	2 Medical Ex	Physician: To the taminer: On the t	pasis of exami	nowledge, dea nation and/or i	ith occurred nvestigation	at the tim , in my op	e, date and inion, deatl	diplace, a hioccurre	nd due to the d at the time,	cause(s) a date and p	nd manner a lace, and du	is stated. ie to the cause(s)	
	thin 2	Med	29b. Signature and	ttle of certifier	and mar	ner stated.		290	. License	number			29d. Date	signed (Mo	nth, Day, Year)	
	E 3 E 8		\ X		S	Jan	_	1	1	491					- 2007	
			20 Name (24 24	Con of some) accomplated as	en of death //-	om 22-1 (T	/		, ,,					•	
	6		30 Name and add	M.A. RI	A 2 CL				1	1~71	ltic:	m M.	0 2.1	090		
	Sta	te.	31. Date filed (Mo	nth Pay, Xears	2007 32	Registrar's Sig		madi 1			,,-,	-,((- 70		
	Registr		•	MAN T T	CUUI Juli		Ja. Jag									

Morton

3

			1 - Fo Amend State Registrar	#18 Per	FIF 6869 1		d / Jh epa		f Health	and M			0.7	00475
	Dhusisi		1. Decedent's Name	e (First, Middle, La	ast)	· ·					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medi		Anntone	etta				Quee	n		Janu		2007	2305
	Examir		4a. Facility Name (I	If not institution, gi	e street and number	1+0	spital	4b. City, Town	n, or Locatio	on of Death	11	4g County	of Death	
			Unive		Segnie	cial	ity							
	Funeral		5. Social Security N		Sex 7. A 1 □ M X □ F		last birthday)	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of Bi	rth ay, Year) 2 59	9. Birthpla Countr	ace (State or Foreign
	Director		216-74-7 Usual Residence of	/183		47	Yrs.				11 1	2 59		" MD
	and w		10a. State	10b. County	-	10c. Cit	y, Town or Lo	cation					10	d. Inside City Limits
	Maryl f sho	ō	MD	NA		В	altimo	ore						1X1Yes 2 □ No
	with the Maryland a or 28a-f show t be notified at	Funeral'Director	10e. Street and Nu					10f. Zip Cod	 le			10g. Citizen of V	Vhat Countr	v?
2	3a or	قِ ا	2825 Pa	arkwood	Ave				212	17		_	5 . A .	,
+	ms 2	Jera	11. Marital Status	221111000	12. Was Deceden		.S. 13. V	Vas Decedent of Yes, specify C			ecify Yes or No	o- 14. Rac	e - America	
12 6	after or ite	Ē	1 Never Marr	ied 2 X Married	Armed Forces 1 ☐ Yes 2 If Yes, Give						Rican, etc.)		k, White, et	
ntoina 21215-0036	ral", c	i by	3 Widowed	4 ☐ Divorced	Year or Dates:			Yes XI	No <i>Sp</i> ec	ıry:		Specify	: B1	ack
5-0	72 hc	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Deced	lent's Usual Oc kind of work do OO NOT use ret	cupation ne during m	ost of worki	na	16b. Kind of Bu	ısiness/Indu	istry
7 5	ne. han e	ğ	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	1	ing As				Nursi	na u	omo
Ah da	led w lygie her t	S	12th gra		na		NuLS.	ing As			(Fire 4 - 8 6) at all 1			
A Pund	ntal Hed of	Be	Andrew (` '	9							e, Maiden Surnam illia ms		
2	hould d Me nark natio	은	19a. Informant's Na		(Type Print)		10h Mailin	a Addross /Ctr				per, City or Town,		Dougla N
\ S Marvi	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			•	daughter		1					more, N		1217
	Hear Hear tem	10.38	20a. Method of Disp		daughter	20b. F		sition (Name of natory or other)			ate	20c. Location -		
U C C Y	ages ent of rt: If I			☐Cremation 3 [5 ☐ Other (Speci	Removal from State	:	emetery, cren Mt Zic		place)	1/13	/07	Baltin	-	
~ <u>∓</u>	artme ortan injur		21. Signature of Fu		**				dress of Fa		707	Darti	iore,	
	permi Depar Impor any ir			In The	- K. J		M_{α}	Name and Ad RCh F	/H We	est Avo.	Bal+	imore,	ма	21215
0	PA Bro		23a. Part1. Enter t	disease, or con	nplications the ause	d the deat								Approximate nterval Between
	Physician		Immediate Cause ((Final	0		000		0,000	200			Ċ	nterval Between Onset and Death
	/Medical		disease or condition resulting in death)	on 💣	a. Due to (or as		uence of):	tonat	0017	C 12C				
- 1	Examiner		F		, Dia	oches	y m	elling	8	MEC	TT			
	D #	ner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying	Due to (or as	a conseq	uence of):	11						
1,19	nd trans	Examiner	Cause (Disease or that initiated events resulting in death) I	injury	· Pare	nish	in	2012 Auc	ieve	\sim				
2092	te be executed ysician and le burial-transit		readiling in dealing	Last	Due to (or as	a conseq	uence of):			\				
687	2 > 2	dical			_ d									
9 ×	death certificat attending phy I for use as the	Physician/Med	IF FEMALE:		23c. If yes, outcome	nf progns	anov.						11 700	
Box	atten for us	ian	23b. Was deceden	months?	1 ☐ Live birth	2 ☐ Feta	Ideath 3□	Ectopic pregna					e of delivery nth D	/ Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☑ 9 ☐ Unknown		9☐Unknown	it ume or a	eam 5_	Other (specify,	/					
	that that ed by		Part II. Other signif	ficant conditions	contributing to death	out not res	ulting in the un	derlying cause	given in Pa	rt I.	23e. Did 1	tobacco use conti	ibute to the	cause of death?
Division or Vital Records.	The law requires that the death certificative has been signed by the attending phoage 2 should be detached for use as the	d by									10	Yes 2 No	3 ☐ Probal	bly 4 Donknown
Ö	w req	Completed									24a. Was	an 24h 1	Nere autons	sy findings available
Be	sician: The law certificate has trirector, page 2 s	Ę.									auto perfe	psy ormed?	prior to comp teath?	oletion of cause of
ta	ysician: The lis certificate hadirector, page		25. Was case refer	red to medical					26 Pls	oce of Death	1 Yes (Check only o		☐Yes 2	L d No
<u>`</u>	Physician: r this certifica ral director, p	o Be	examiner? 1 ☐ Yes 2 🗹	/	Hospital: 1 Inpat	ent 2□	ER/Outpatient	3 □ DOA (Other:			dence 6 □Othe	ar (Specify)	
ō	fing Phys I. After this funeral di	Ë	27. Man or of Deat		28a. Date of Inj (Month, D	ury	28b. Time of		njury at Vork?			how injury occurr		
Ö	Attending r death. ector: After by the fune	atio	1 ∠ Natural 2 □ Accident	5 ☐ Pending investigatio		ay rear)	Injury		Yes 2	□No				
<u> </u>	l or Attend after death. Director: /	iệ	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		jury - At ho	ome, farm, stre	et, factory, offic	ce	2	28f. Location (Street and Number	er or Rural I	Route Number,
	tal or rs after al Dir	Certification:	_								01.) 0 70	m, oraco		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ca	29a. Certifier (Check only	1 ☑ Certifying Pl 2 ☐ Medical Exa	hysician: To the best miner: On the basis	of my kno	wledge, death	occurred at the	e time, date	and place, a	and due to the ed at the time.	cause(s) and ma	nner as stat	ted. he cause(s)
	To the Hc within 24 To the F. completel	Medical	one)		and manner s	tated.								
	5 ¥ 6 ©		29b. Signature and	title of certifier	~	3			ense numbe			29d. Date signed		
			20.11	// 0				7	ANA	- 11.	20 00	GW Th	-08-	0/
	3		30. Name and addr		completed cause of	eath (Iten) احراک	123a) (Type, F	Print)	12/14	2/2	30	ME AND		
	Sta	ite	31. Date filed (Mon		32 Regist	rar's Signa	iture			•				
	Regist		, } ,	AN 1 1 20	07 Person	0 10	Son	(Mel,						
				white make the termination of th	Butter and the state of the	97.	- N P							

DHMH 17 Rev 1/2001

Deputing the property of the chemistron plan area and multiple company of the chemistr				1 - For State Registrar	State of Maryla		rtment of H		lental Hygie	2001	00476
A PROPERTY OF THE PROPERTY OF		Physici	ian	Decedent's Name (First, Middle, Last	t)	D				Day Year	3. Time of Death
CREATER SALTIMORE CREATER SALTIMORE Sook Service Number 1 Sook Service Number 2 Sook Service Number 2 Sook Service Number 2 Sook Service Number 2 Sook Service Number 2 Sook Service Number 2 Sook Service Number 3 Sook Service Number 2 Sook Service Number 3 Sook Service Number 4 Sook Service Number 5 Sook Se		/Medi	cal					r Location of Death	January	-,	
The control of the co			ici	GREATER BALTIMOR	E MEDICAL CE			N		BALTIMO)RE
Second Continues (b) United Second Control Second Con				217-90-2071					(Month, Day, Ye	9. Birth Con	nplace (State or Foreign unity) Cairling
Source for Number 10		/land			10c.	City, Town or Loca	ation				10d. Inside City Limits
Section Continued Contin		e Man	ctor	MD.		BaH:	more				Yes 2□No
11. Month States 12. Winds Environment 12. Winds Environment 12. Winds Environment 12. Winds Environment 12. Winds Environment 13. Winds E		E 2 2	Dire		1-00	10.000	10f. Zip Code	1711	10g.	Citizen of What Cou	untry?
The state of the s		death ms 23	neral				as Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	ican Indian,
Companied Comp	98	s after or ite			1 ☐ Yes 2 No				Hican, etc.)		, etc.
County by Privacian County Privacy County	~ 8				Year or Dates:	16a Decede	nt's Usual Occup	ation	168	10	ndustry
The property of the property o	7,	7 01	nple			(Give ki	nd of work done of NOT use retired	during most of worki ii) i	ng		,
The property of the past of th		Pa Sa	Co	17. Father's Name (First Middle Last)) isabl		/First Middle Mai		
State State		8 <u>a</u> a g	To Be	11 1 - 1	Couse			EVR	Coope	e F	
State Stat	A Y	2 sho and I	1	19a. Informant's Name/Relationship (7	1 - 1	19b. Mailing	Address Street	and Number or Rura	I Route Number, C	44.4	ip Code)
State Stat	a) e	Healt Healt tem 2		20a. Method of Disposition		Place of Disposit	tion (Name of				Z/Z/4 Fown, State
23a. Price Control Con	5,00	Page: ent o nt: if				Vetro (0 1		11.07 7	Betim	CE MA
23. Physician (According to Sequence of Se		ermit. Separtri mporte iny inju		21. Signature of Funeral Service Licen:	See O		Name and Addres	ss o Earility	ineral H	me PA	
Physician Medical Examiner Physician Medical Examiner Medical Exa	\propto	40344	9	23a. Parl 1. Enter the disease, or comp	olications that caused the de	1 2	222 60	North +	4 would	Brito. 1	
Part Control		Physician	1	In ck, or heart failure. List only of Immediate Cause (Final	one cause on each line.	2000	de la	cad. H.	_	1	Interval Between
Sequencially list conditions, and with a set of the sequence o	9			resulting in death)	Due o (or as a cons	equence of):	11	201912			2 474)
The state of the s	,,,	3	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):	Live	vain	و	2	scars
The state of the s	b	ecuted and transit	amlr	that initiated events	· Livin C	mch	hepu	41,			year 1
The state of the s	'60.	be exessician a		rosuming in south) cast	Due to (or as a cons	equence of):					U.
The state of the s	89	tificate ig phys	ledic		d	_					
The state of the s	Box	ath cer ttendin or use	lan/N	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Fe	etal death 3 E					
The state of the s	0	the de y the a	hysic			fdeath 5∐0	Other (specify)				24,
The state of the s		signed b		Part II. Other significant conditions co	ontributing to death but not r	esulting in the und	erlying cause give	en in Part I.			
The state of the s	S	aw req s been 2 shou	plete						24a. Was an		opsy findings available
The state of the s	E Re	The ta	Com			<u> </u>			performed	prior to co death? No 1 \(\subseteq Yes	ompletion of cause of 2 ☐ No
The state of the s	Vita	sician: certific rector,	Be	examiner?	Hospital:		Othe	90			
The state of the s	ţ.	y Phys er this eral di		27. Manner of Death	1 linpatient 2		3LI DUA	4 Nursing Hor			fy)
The state of the s	ion	ending eath. or: Aftu	atlo	2 Accident investigation		Injury					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	Divis	al or Attu s efter de il Directo	Sertific	- determined	28e. Place of injury - At	home, farm, stree cify)	t, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4701 N CHARLES STRECT TOWNS MD Z1Z04 WILLIAM TYLLING MD State 31. Date filled (Month, Day, Year) 32 Registrar's Signature		Hospit 24 hour Funera etely fille	dical ((Check only 2 Medical Exam	Iner: On the basis of exami	nowledge, death o nation and/or inve	occurred at the tim stigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as and place, and due t	stated. lo the cause(s)
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		To the within To the complete	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		0		> yaunm	1 finh		D5	7361		114/07	
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		2			ompleted cause of death (It	em 23a) (Type, Pr	int)	1204	Willia	w hu	VKINIMA
				31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ELIZABETH 7:35P M HALL RIESNER JANUARY 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day) Year)
April 10,1925 Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 212-56-4827 81 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notifled at Yes 2 No Directo Maryland | Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 21704 U.S.A. 5955 Quinn Orchard Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or ite 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Completed by XXWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Womens Club yrs. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pendleton Henry Hall Elizabeth Mae Barham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6323 Bentridge Drive Charlotte, North Carolina 28226 Virginia R. Dunn (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1XXurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery: 1-12-07 Pikesville, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complicative that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Week Physician Oneumania /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrilation 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate sspital or Attending Physician: Thours after death.

Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier D516 43 Shoh mo

N

State Registrar 45

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

honson

redench mp 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Thoma

			1 - For Amend #5 Per FH C	863t41/1.1/d/	agylan	id / Depa <i>Cer</i>	rtme <i>tifica</i>	nt of H	lealth a Death	and M		giené Reg. No.	2007	00478
			1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Edna M. R	obinette							JANUARY	08		4:30 PM
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. Cit	y, Town, or	Location o	f Death		4c.	County of Deatl	1
				OSPITAL					imore					
	Funeral		5. 31 761 26 170 5 0 nber 6. S	ex 7.Ag □M 2□F	e (In yrs.	last birthday)	If Und Month	er 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birth Co.	nplace (State or Foreign untry)
	Director		217-207058	x	80_	Yrs.					8-1-	26		MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	MD			Balt	imo	re C	itv					1 ☑ Yes 2 ☐ No
	1989 H	Director	MD 10e. Street and Number				-	ip Code				10g. Citiz	zen of What Co	untry?
	3a or		2631 Northsh	ire Driv	Δ		2	1230				TT	SA	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent		.S. 13. V	Vas Dec	edent of H	ispanic Orio	gin? (Spe	cify Yes or No		14. Race - Ame	
_	affer Price		1 Never Married 2 Married	Armed Forces?	No				n, Mexican	, Puerto F	Rican, etc.)		Black, White	
0500-c	hours after turei', or ite al Examine	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give X Year or Dates:	l		⊔ Yes	2/2 No	Specify:				Specify: Wh	ıte
ה ה	72 h natu dical	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of v	vork done d	during most	of workir	ng	16b. Kir	nd of Business/	ndustry
7	g e g	gu	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT	use retired	0					
V	filed within 72 Hygiene. Ither than "nat int, the Medici		12				Ban	k te	11er	d. N	(First, Middle,		Bankin	g
Ē .		Be	17. Father's Name (First, Middle, Last)										Sumame)	
Š	2 should and Men is marke sumatic	٩	Charles Ken			40h A4silia	_ &	(Ct1			C. F1		T C4-4- 7	"- O- #1
	2 6 7 2		19a. Informant's Name/Relationship (•					. ,	r Town, State, Z	
e) O	s 1 and f Health item 27 other tr		Sandra Sowers 20a. Method of Disposition	- Daugh		Place of Dispos			oor				d, MD	
٥			1 ☐ Burial 2 ☐ Cremation 3 ☐		0	emetery, crem	natory o	rother plac	· .		ate -07		altimo	
Бантто	rtant rtant		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Ва						etery			
n n	permit. Page Department of important: if eny injury of once.		21. Signature of Vollerar Service Cicel	2.01			. 1401116	and Addres	ss or racing	Brad	lley-A	sht	on Fun	eral Home
ė			23a. Part1. Enter the disease, or com	plications that caused	the deat								oad, 2	Approximate
ı			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.				•					Interval Between Onset and Death
ı	hysician /Medical		disease or condition resulting in death)	a. PULM Due to (or as			BOLL	M						DAYS
	Examiner		1			JLABLE	STA	715						DAYS
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):	OIR	10						לוחע
	outed ansit	Examiner	Cause (Disease or injury that initiated events	c										
ĵ	be executed icien and burial-transli	Ĕ	resulting in death) Last	Due to (or as	a conseq	uence of):								
0 0 0 0	cate be executed physicien and the burial-transit	dicai		d										
ĕ	the death certificate y the attending physiched for use as the	Med	IF FEMALE:					_						
X D D	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			Ectopic	pregnancy				2	23d. Date of deli Month	very Day Year
5	at the dea by the ai tached fo	Sici	1 ☐ Yes 2 ဩNo 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of d	leath 5□	Other	specify)					WOTH	Day
ĭ	hat thid by setacl	币	Part II. Other significant conditions of	ontributing to death h	ut not rec	ulting in the ur	dorhio	LOGUEO GIV	on in Part I		23a Did to	phacen u	se contribute to	the cause of death?
Š,	requires that pen signed b hould be deta	i by	Tarris official significant contained	oninoding to doding	or nor ros	oning in the di	i deriyiri	i causo givi	911 III T CATC 1.			es 2[bably 4 DUnknown
cords,	w require been si should b	Completed												
d)	0 5 0	E E									24a. Was autop		prior to death?	topsy findings available ompletion of cause of
	E age a										1□ Yes	2 🗷 No	1 ☐ Yes	2 No
=	Physician: 1 this certificerral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
0	Phys r this ral dir	7	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of		28c. Injun Worl	4 ∐ Nur		8d. Describe h		Other (Spec	ify)
0	th: Afte	텵	1 Natural 5 Pending 2 Accident investigation		y Year)	Injury	М		k? Yes 2 ☐ N	1				
DIVISION	f or Attending P after death. Director: After I I in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At he	ome, farm, stre	et, fact	ory, office		2	8f. Location (S	Street and	d Number or Ru	ral Route Number,
5	safte safte ii Dir	ert	4 Homicide	building, et	c. (Specif	y)					City or Tox	m, State)	,	
	bopit hour uners ly fille		29a. Certifier 1 Certifying Ph	ysician: To the best	of my kno	wiedge, death	occurre	d at the tim	ne, date and	d place, a	nd due to the	cause(s)	and manner as	stated.
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	one)	niner: On the basis o and manner st	ated.	mon and/or inv				ui occurre				
	To t To t	Σ	29b. Signature and title of certifier				2	9c. License				29d. Date	e signed (Monti	, Day, Year)
) Wil	W	D			42	-034)		JANI	JARY 08	2007
	10		30. Name and address of person who				·							
	10		RAHUL JAIN 31. Date filed (Month, Day, Year)		V AVI		BALT	IMORE	- WD	217	129			
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	ais orgina	As A	- 60							

DHMH 17 Rev 1/2001

KOBINETTE, EDNA

			1 - For State Registrar	State of M	laryland		artmen rtificat				lental Hy	giene Reg. No.	07	00479
	Physic	ian	Decedent's Name (First, Middle, L	,							2. Date of De Month	eath Day	Year	3. Time of Death
	/Medi	cal	ANNA ROEDIGE					-			Janua	ry 7, 2	2007	10:00 a ^M
	Exami	ner	4a. Facility Name (If not institution, g St. Mary's Nurs				-		Location of	of Death		ĺ	nty of Death	
	Funeral			Sex 7. A	ge (In yrs. la	st birthday)	If Under	1 Year	If Under		8. Date of Bi		Mary 9. Birth	S place (State or Foreign intry)
1	Director		218-56-8950	1 □ M 2 💢 F	95	Yrs.	Months	Days	Hours	Min.	June 1	rth ay, Υθατ) 5, 1911	Con	necticut
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	ocation							10d. Inside City Limits
	Manyl f eho	Į.	Maryland St. Mar	t.		arlot		1 1						1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number	.у Б	CII	aliul	10f. Zip					10g. Citizen o	f What Cou	intry?
	th wit	Funeral Director	38245 Walter Co	ourt			2	0622				U.S.A	. •	
	teme	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	o- 14. R	ace - Ameri ack, White	
36	ours atter death with the Marylar ral', or Iteme 23a or 28a-f ehow Exactinal mout be notified at	by Fu	1 ☐ Never Married 2 ☐ Marned 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give	No		1 ☐ Yes 2		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Spec	ifu.	
8	within 72 hours atter death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow is Medical Exeminat Ne notitiou at	ted t	15. Decedent's	Year or Dates:		16a. Deced	dent's Usua	I Occupa	ition			16b. Kind of		ite
215	hin 73	piet	(Specify only highest g	rade completed) College (1-4or	5+)	(Give life. l	kind of wor DO NOT us	k done d e retired,	u <i>ring</i> mos	t of work	ing	TOD. KING OF	003111033/11	lousily
21	ed wit	Completed	5		347	Home	maker					Own H	ome	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic event, It a Max	Be	17. Father's Name (First, Middle, Las	st)								, Maiden Suma	ame)	
7	hould d Mer marke maric	P	Paul Osedach 19a. Informant's Name/Relationship	(Trung Paint)		401-14-10		/2:		-	Verke			
Ma	s 1 and 2 should be filed within 72 hours aft I Health and Mental Hygiene. Item 27 Is marked other than "natural, or other traumatic event, If a Medical Exertical		Paul Roediger -									өг, City or Tow e На11,		
re,	ot Hea		20a. Method of Disposition		20b. Pla	ice of Dispo				- 100	Date	20c. Location		
Ę			1 🕅 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State					L	1/1	2 / 2007	Brentw	hoor	Maryland
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Li				. Name and				2/2007			imore Ave.
_	Deg ding		Abutter	1 ay								. Hyat		le, MD 20781
н			23a. Part1 Enter the disease, or cor shock, or heart failure. List ont	mplications that caused y one cause on each li	d the death. ine.	Do not ente	er the mode							Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	la/ Co	nge	othe	ne	bl	ear	ur	Har	Unn	1.	Onset and Death
100	Examiner		1	Due to (or as	a conseque	ence of):		to		1-1-1		Jun		
4.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	а солѕедие	nce of):		10		Civi	ana			
$\sqrt{}$	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
,	e exerian ar	Ex	resulting in death) Last	Due to (or as	a conseque	nce of):				_				
8760,	ate hy:	dlcai		d										
9 x	eath certitic attending p	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnance	~v								
Вох	death a atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	eath 3	Ectopic pre						ate of delivi	ery Day Year
0	t the c by the achec	hysi	9 Unknown	9☐ Unknown										
S, P	res that the de signed by the a be detached t	by P	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the un	derlying ca					obacco use cor	ntribute to t	ne cause of death?
ord	w require been si should I		End	terne		en	ry-		use	an	L 10'	/es 2□No	3 🗌 Prot	abiy 4 ∭U⊓known
ec	elawi hasbe	Completed	Hyper	teine	~		0				24a. Was autop		Were auto	psy findings available mpletion of cause of
E H		Co									perfo 1 ☐ Yes	rmed?	death?	
Zi:	Physicien: T this certiticet ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o			
ot	Physic ruthis aral di	. To	1 Yes 2 No	1 Inpatre		NOutpatient 8b. Time of		le Injury	4 DNoi			dence 6 🗆 Ot		γ)
ion	Attending r death. ector: Alter by the fune	ation	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	lc. Injury : Work? 1 🔲 Y	95 2 □ N			ion injury cocu	1100	
Division of Vital Records,	ar deg	Certification:	3 Suicide 6 Could not I		ury - At hom	e, farm, stre	et, factory,	office		- 1	28f. Location (5	Street and Num	ber or Rura	l Route Number,
Ö	ital or rrs att ref Dir	Cer									City or Tov			
	To the Hospital or Attending Physicien: within 24 hours alter death within 24 hours alter death. To the Funerel Director: Alter this certific completely tilled in by the funeral director,	edicai	Z Medical Exa	hysician: To the best miner: On the basis of	examination	edge, death n and/or inv	occurred a	t the time	, date and	place, a	and due to the	cause(s) and m	anner as s	ated.
	thin 2 thin 2 on the	Med	29b. Signature and title of certifier	and manner sta	ated.			License				29d. Date signe		
)	⊢ 3 ∓ 8 ⊣	20		ally					288	8				07.
	1	-	30. Name and address of person who	completed cause of d	eath (Item 2	3a) (Type. F		- 0	00				1 1	U 7 .
	1		Rakhi Krishnan,				,	ad,	Leon	ardt	own, Ma	ryland	20650)
	Sta	-	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	е .								
5.6	Registr	al	JAN 1 1 200	Moreage	d.	Board	11							

07-00085

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Koby Rockwell State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Rockwell Medical Examiner Koby January 3, 2007 1846 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death University of Maryland Medical Center Baltimore N/A 5 Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY 9 Birthplace (State or Director Months Days 216-70-3297 Hours $_{1}$ X $_{M}$ July 11,1958 48 Country) Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show Yes 2 X No notified at once. Baltimore Dundalk with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 1329 North Point Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be death v Armed Forces? Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married White, etc. 1 X Yes Yes, Give Year 1976-1980 "natural", Widowed Divorced Yes 2 X No specify Specify White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than 'traumatic eveut, the Medical Baltimore, MD 21215-0036 be filed within Electrical Electrician 12 Years and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Nancy Dale Hunt Be Michale Francis Wieczynski 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pok H. Rockwell (Wife) 604 Reservoir Street Baltimore, MD 21217 and 2 of Health 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State 1/8/2007 Towson, Maryland Hilltop Service Corp nent Donation 5 Other 0.0 2. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Maryland 21222 Signature of Funeral Service Licensei III. Dundalk, Maryland 7922 Wise Ave Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure List only one cause on each line /Medical Between Onset and a Contact Gunshot Wound of Chest Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pur Physician/Medical UNPENDED AMENDED Box 68760. ing phys as the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown the by Part II. Other significant conditions Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate Yes 2 V No Yes 2 No To the Hospital or Attending Physiciau: 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital: 1 ✓ Inpatient 2 Other₄ After this 1 🗸 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ٩ 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Jan 3, 2007 Natural 1441 hrs Subject shot self s after death Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 4225 Audrey Avenue, Brooklyn, MD within 24 hours af To the Funeral D determined (Specify) Single Family 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 4, 2007 unala 10X me and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 6, 2007 **Physician** 11:50 A M Ida C. Rosenberger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 ☐ M 2 💢 F 213-14-4599 91 November 28, 1915 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Mary land Howard County Dayton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 13556 Argo Drive 21036 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Dignan Anna Dietz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane P. Kastner/Daughter 13556 Argo Drive Dayton Maryland 21036 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/07 Baltimore Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licenses motina Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a DEMENTIA disease or condition resulting in death) /Mèdical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transi and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? certificate has been signed by the atte rector, page 2 should be detached for Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \mathbf{X}$ Other (Specify) 1 ☐ Yes 2 No HOSPICE Certification: To after death.

Director; After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Saltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

IDA ROSENBERGER

Registrar's Signature

			1_ State	oartment of Health and M ertificate of Death		ne No.2007 00482
	14 18 -		Registrar 1. Decedent's Name (First, Middle, Last)	Jundate of Beath	2. Date of Death	3. Time of Death
	Physicia /Medic		George C. Roveti		January 1	0, 2007 12:09 A M
	Examin	Arres	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			111 Hamlet Hill Road	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 120-40-2082 79 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1927 Hungary
\$200	TO O		Usual Residence of Decedent		0413 10,	
	arylar show	5	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ★ Yes 2 □ No
	the M 28a-f notifie	Director	Maryland N/A BALTI	MUKL 10f. Zip Code	10g.	Citizen of What Country?
	3a or st be		111 Hamlet Hill Road	21210		U.S.A.
	ems 2	Funeral		 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
9	2 hour	ted t	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b	b. Kind of Business/Industry
215	thin 7, ie. an "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working DO NOT use retired)		
121	filed within Hygiene. Ither than "		5+ Me	dical Doctor	(First, Middle, Maid	Hospital
anc	d be fi	To Be	Charles Ernest Roveti			ene Bakacs
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene with a fire 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 21be notified at other traumatic event, the Medical Examiner must be notified at	ř		iling Address (Street and Number or Rura		
	Health a tem 27 is other tra			64 Schwaninger Road		e, Maryland 21673
Baltimore,			1 Burial 2 Libermation 3 Hemoval from State	rematory or other place)		c. Location - City or Town, State
Itim	그들은		4 Donation 5 Other (Specify) Hilltop	Service Corp.: 1-11	-2007	Towson Maryland
Ba	permi Depar Impor any Ir once.		Hawl Hergan	22. Name and Address of Facility Ruc 1050 York Road T	owson, Ma	ryland 21204
1	*		23a. Part1. Enter the disease, or complications that caused the de uh. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between
i de	Physician		Immediate Cause (Final disease or condition	m Cancer		Onset and Death
6	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
2 (e.	Sequentially list conditions, if any, with immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury			
	cuted nd ransit	Examine	that initiated events C.			
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
387	icate b physic	dical	d			
Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
	e deat	sicia		5 Other (specify)		Month Day Year
P.0	ires that the de signed by the a be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
or Vital Records,	quires n sign ald be	d by			1 ☐ Yes	No 3□ Probably 4□Unknown
900	aw require is been się 2 should b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä		Com			performed	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death		
0	Phy rthis rald	To	27. Manner of Death 28a. Date of Injury 28b. Time	e of 28c. Injury at	me 5 🕰 Residence 28d. Describe how i	e 6 Other (Specify) njury occurred
ion	Attending Ph r death. ector: After th by the funeral	atior	Matural 5 ☐ Pending (Month, Day Year) Injur	y vvork? M 1 ☐ Yes 2 ☐ No		
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
Ω	pital ours al		29a. Certifier	eath occurred at the time, date and place.	and due to the caus	se(s) and manner as stated
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	^		Faul Cloms MD	D30129		1/13/2001
	10		30 Name and address of person who completed cause of death (Item 23a) (Tyr	e, Print) Churlon S	T. RAN	TIMO MD 71204
	Sta	ate	31. Date filed (Month, Day, Year) /32 Registrar's Signature	10 01 41 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	111111111111111111111111111111111111111
	Regist	rar	JAN 1 1 2007 Brewer B. A	sorte)		

State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death, 4a. Facility Name (If not institution, give street and number) Examiner NUBING 1 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2 220-09-551 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location with the Maryland 10a. State 10b. County "natursi", or itsma 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Columbia Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code **APT 113** 21044 6336 Cedar Lane United States of America death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 從 No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by X□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 Housewife Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file Deperment of Health and Mental Hy Important: If Itsm 27 is marked oth any linjury or other traumatic avant one. Be Annie E. Elbon Howard Dorsey Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3712 Mesa Court, Ellicott City, Maryland 21042 <u>Ellen Burns</u> (Niece) 20c. Location - City or Town, State 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 01/13/07 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitLoring Byers Funeral Directors, Inc 21. Signature of Funeral Service 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death nt Enter the disease, or complication d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finat myo Condia inforcton Aude **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence e Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 1 Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. 27. Manper of Death Injury at Work? After Division Injury 1 Naturat 5 Pending 1 Tyes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053700 MI 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie MD 14300 STE Gallant TOX (HHWLH) lance KAS 31. Date filed (Month, Pay, Year) 32 Registrar's Signature State Registrar

			1_ For State	icase			nd / Dep	artment of H	lealth and M	-	piene	. 00484
			Registrar 1. Decedent's Name (First,	Adiabatto I a	adl		Ce	rtificate of	Death		leg. No.	00.0.
	Physic	ian			<u> </u>					2. Date of Dea Month	Day Yea	3. Time of Death
	/Medi		Alfredo Ren			6 1		1 41 61 +		Jan. 8	2007	1:50 P M
4	Exami	ner	4a. Facility Name (If not ins Charlestown				± 37		r Location of Death		4c. County of D Baltin	
	\- <u>-</u>		5. Social Security Number	6. 5		. Age (In yrs.			If Under 24 Hrs.	0.0		
	Funeral Director		220-50-0602		M 2DF	. Age (in yrs. 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year) 9.1	Birthplace (State or Foreign Country)
			Usual Residence of Decede		Λ	- 07				July 8	1919	taly
	/land		10a. State 10b. C	ounty		10c. Ci	ty, Town or Lo					10d. Inside City Limits
	Man f sh	ţō	MD Ba	ltimo	re		Owings	Mills				1 □Yes no
	r 28e	rec	10e. Street and Number					10f. Zip Code			Og. Citizen of What	Country?
	r death with the Marylan tems 23e or 28e-f show er raust be rediffed at	Funeral Director	9450 Wordsw	orth	Way #204	ŀ		211	17		Italy	•
	death	Jere	11. Marital Status		12. Was Deced	lent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - A	merican Indian,
9	after or ite	Ē	1 Never Married 2] Married	Armed Ford 1 Tyes 2 If Yes, Give	ces? 2[X]No				Rican, etc.)	Black, W	
93	ral', o	by	3X Widowed 4 ☐ Div	orced	Year or Dat	es:		1 ☐ Yes 21 No	Specify:		Specify:	White
5-0	n 72 hours after death with the Maryland "natural", or items 23e or 28e-f show after Ever in et must be revilled at	Completed	15. Dec	cedent's Ed	ducation de completed)		16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Busine	ss/Industry
2	ithin	nple	Elementary/Secondary (0		College (1-	4or 5+)	life.	DO NOT use retired	()	nig .		
21	ed w ygier yer th	Cor	8		n/a		Tail	Lor			Texti]	.e
pu	be fill tal H d oth	Be	17. Father's Name (First, M.	iddle, Last)					18. Mother's Name			
yla	ould Men arke	ို	Giuseppe Ric							Evangeli		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "many injury or other treumatic event, Item Mealth 2008.		19a. Informant's Name/Rela								, City or Town, State	, Zip Code)
	and ealth m 27		Nadia Togno	ccn1/	daugnter		200	Pable Di				
ore	of H		20a. Method of Disposition ty□ Burial 2 □ Crema	ation 3	Removal from Si	tate 20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other plac			20c. Location · City	
Ë	Pag ment ent:		`4 ☐ Donation 5 ☐ Oth	er (Specif	y)	Lak	ceview	Cemetery	1/12/	07	Sykesville	e, MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Se	wice Lieer	isee		22	2. Name and Address	s of Facility	of Dul	morr Volle	Tno
ш	205 2		Michael		agle		10	W. Padoi	nia Rd.,	Timonium	ney Valle n, MD 2109	3
			23a. Part 1. Enter the disea shock, or heart failure	List only	plications that cau	used the deat	h. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arri	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				(`ć	oliti's				Onset and Death
	/Medical		resulting in death)		Due to (or	r as a conseq						
	Examiner		Cognostially list conditions		h							
-	<u> </u>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to (or	r as a conseq	uence of):					
	be executed ician and burial-transit	ami	that initiated events		C							
0,	e exe ian a urial-l	Ĕ	resulting in death) Last		Due to (or	r as a conseq	uence of):					
3760,	ate be nysici	cal			d							ļ.
89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	-		581.	_					
Вох	th ce tendi	an/I	23b. Was decedent pregna		23c. If yes, outco	me of pregna		Ectopic pregnancy			23d. Date of d	
	ed for	slci	in the past 12 months?			nt at time of di		Other (specify)			Month	Day Year
P.0	at the by the stach	hy	9 🗆 Unknown									
	es th gnec	by	Part II. Other significant co	nditions c	ontributing to dea	th but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ord	w requir been si should	ted								1 🗆 Ye	s 2.2100 3□1	Probably 4 Unknown
Records,	lawr as be 2 sh	Completed								24a. Was ar	24b. Were	autopsy findings available ocompletion of cause of
E.	hysicien: The law his certificate has t I director, page 2 s	mo:								perform	ned? death?	s 2 No
Vital	Physicien: this certificatal director, p	Bec	25. Was case referred to me	edical					26. Place of Death			
f \	ysic lis ce direc	To	examiner?		Hospital:	patient 2 🗆	ER/Outpatien	t 3 DOA Othe			nce 6 Other (Sp	ecify)
Jo L	<u>□</u> = 'a		27. Manner of Death 1 Natural 5 □ P	ending	28a. Date of (Month.	Injury Day Year)	28b. Time of Injury	28c. Injury Work	at 2		w injury occurred	
Division	ath. or: Af	atic	2 Accident in	vestigation		,,	,,		es 2□No			
Σį	I or Attendi after death. Director: A I in by the fu	tific	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	ould not be etermined	286. Place of	f Injury - At ho	me, farm, stre	eet, factory, office	2	28f. Location (Str City or Town	eet and Number or F	Rural Route Number,
	rs aft	Cer								Cy GI TOWIT	Julio/	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:	29a. Certifier 12 Certifier (Check only 2 Med	tifying Ph	ysician: To the b	est of my kno	wledge, death	occurred at the tim	e, date and place, a	ind due to the ca	use(s) and manner a te and place, and du	is stated.
	the Find 24 the Find Plate	edi	Uney		and manne	r stated.	and and or inv	osugation, in my op	macri, death occurre	o at the time, da	te and place, and du	e to the cause(s)
	To the within To the comple	≥	29b. Signature and title of Co	/				29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
	,		• / .	/, (MD			D4)	44)	-	GALGLY 1	T205, F
	Ve		30. Name and address of pe		completed cause	of death (Item	-	- 1	10 (cm	, (c	tensilo	Miss
-	01		31. Date filed (Month, Day,			ristrar's Signal	Maid		100	, , ,	1000	V- 300 1
	Sta Registr		an a s	4 00	07	, on an original	ture doe	all I				
	1.031011	2 42	JAN	1 10	U/ ALCOHOL	1640 50	13 3 44	- Charles				

			For State Registrar	State of M	laryland		artment tificate			nd Mei		gienę Rog. No	$^{2}1111I$	0	04	85
	Physici	5 B	1. Decedent's Name (First, Middle	e, Last)						2.	Date of De Month	ath Day	y Year	1	Time of D	
4.4	/ /Medi		JAMES	SCOTT							01	05	_	7 1	,05	РМ
	Examir	ier	4a. Facility Name (If not institution	n, give street and number,)		4b. City, T	Town, or L	ocation of	Death		4c.	County of Dea	ith		
	2.	***	Eastpoint Re	hab. & Nu	rsing	ne himbola i i	Bal If Under 1	time	ore If Under 24	4 Hrs 0	D-1(D)		n/a	45 I	(0)	
n	Funeral Director		214-16-7399	1 XM 2 ☐ F	ge <i>(In yr</i> s. Ta 8 7	Yrs.		Days	Hours	Min.	Date of Bir (Month, Da	y, Year)		_	(State or F	-oreign
			Usual Residence of Decedent							10	7-05	-191	9	P	4D	
	nylan thow		10a. State 10b. County		10c. City,	, Town or Lo	cation								nside City	
	Be-f	Director		imore		Gwyn	n Oak							1	☐Yes 2	.X] No
	with th		10e. Street and Number				10f. Zip 0					10g. Citi	zen of What C	ountry?		
	s 23s	iai	526 Gwynn Oal		Francia II G			120		-0.101	VN-		USA		ar	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 🛣 Marr	12. Was Decedent	?	3.	Nas Decede f Yes, specif	fy Cuban,	Mexican, I	Puerto Ric	y yes or No an, etc.)		14. Race - Am Black, Whi	te, etc.		
38	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	41-46	;	1 ☐ Yes 2	XNo.	Specify:				Specify			
21215-0036	be filed within 72 hours after death with the Maryland vial Hygiene. Id other than "natural", or Items 23a or 28e-f show syant, the Madical Exerts are must be southed at	Completed	15. Deceden	t's Education	71 70	16a. Dece	lent's Usual	Occupati	on	- f		16b. Ki	Ame: nd of Business			
218	within 7 ene. than "r	nple	(Specify only higher Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work DO NOT use	retired)	ring most o	or working		Bal	timore	e Ci	ity	
	filed w Hygien ther th	Co	7th	last) unk		Cha	uffeu			<u> </u>		_	Trai		orta	tior
and	be fil bd otl svsn	Be	17. Father's Name (First, Middle,	Last) UTIK							irst, Middle, nde I I		Sumame)			
ž	should be nd Mental marked o umatic svs	2	19a. Informant's Name/Relations	hin (Time Role)		tob Mailie							T- 01.1	7.0		
Maryland	s 1 and 2 should f Health and Mer itsm 27 is marke other traumatic		121 LB 122 WAS	3									r Town, State, Oak , N			7
	s 1 an of Heal itsm 2 other		Gail Scott/Wi 20a. Method of Disposition	fe	20b. Pla	ace of Dispo metery, crer				Date			cation - City or			
10	a 0		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		' I				1,	/12/	07		ngs M:			D
Baltimore,	permit. Page Department Importent: It sny Injury o		21. Signature of Funeral Service		Gar	rison			of Facility[Wylia	o F/F	I P	A. of	Ral	to	<u>Co</u>
ä	Per Per Per Per Per Per Per Per Per Per		* Tanton	(IV. K.	lle	9:	200 L	ibei	rtv H	Rd.	Ranc	lall	stown,	. MI	21:	
			232 Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death.									App	roximate val Betwe	
	Physician	, 1	Immediate Cause (Final disease or condition	-a. Athen		whi	Card	10 1560	(Cin	lar	Dir	POST.			et and De	
100	/Medical	ÿ.	resulting in death)	Due to (or as				(000	1000		200	46				
	Examiner		Sequentially list conditions.	b												
	pg is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):										
H	eecute and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseque	ence of):		-								
9,	e be executed sicien and burial-transit	cal E			4 001100400	31100 017.										
68760,	ta Se	edic		d												
Вох	eath certific attending pl	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of de	livery		
	death e atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pred Other (spec						Month	Day	Yea	ar
P.0	at the de by the a	Physician/Med	9 Unknown	9□ Unknown	_											
	es tha igned be del	by P	Part II. Other significant condition	ens contributing to death b	out not result	ting in the ur	nderlying cau	use given	in Part I.	-	23e. Did to	obacco u	se contribute to	the cau	ise of dea	ith?
ord	w requir been si should	ted	HYPETT	ension							1 🗆 \	/es 2[□No 3□P	robably	4″⊠Unk	known
Records,	e lawr has be je 2 sh	Completed	_ Demoi	nhà							24a. Was		24b. Were at	utopsy fir	ndings ava	ailable
=		် ပ									perfo	med?	death? 1 ☐ Yes			
Vital	Physicien: This certifical ral director, p	Be	25. Was case referred to medical examiner?	Uzanitali				-		of Death (C	heck only o	пе				
of	Phys this al dir	2	1 ☐ Yes 2 € No 27. Manner of Death			R/Outpatien			A MINIS				Other (Spe	cify)		
'n	ling After fune	<u>o</u>	1 Avatural 5 ☐ Pendin		y Year)	28b. Time of Injury	M 286	c. Injury a Work?	it is 2∐No	1	. Describe h	ow injury	occurred			
Division	Attending or death. ector: After by the fune	licat	2 Accident investig	not be Zoo Bloom of In	iury - At hom	ne farm str			S 2 1140		Location /	Street and	d Number or Ri	um I Pou	to Atumbo	
<u>S</u>	after after Dire	Certification:	4 Homicide determ	building, ei	c. (Specify)	110, 141111, 3(11	set, ractory,	Onio		201.	City or Tow	vn, State)) Administration Vi	mai nou	ie ivumbe	<i>'</i> ,
	To the Hospitel or Attend within 24 hours after death To the Funstal Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician: To the best	of my know	rledge, death	occurred at	t the time,	date and	place, and	due to the	cause(s)	and manner as	stated.		
	ne Ho n 24 J ns Fu	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination	on and/or inv	estigation, in	n my opin	ion, death	occurred a	it the time,	date and	place, and due	to the c	ause(s)	
	To the to the comp	M	29b. Signature and title of certifier				29c.	License n	number				signed (Mont		Year)	
	1		/ I'm_				D	43	725	in.			1510			
	7X,		30. Name and address of person	6 C2					1.0-	1	\ i		MD	21	10-	7
	'\		31. Date filed (Month, Day, Year)	mood 19	Kid	Je 1	Locu	(1	Ves	Lmi	n ste	er	, (1)		. 2	1
1	Sta Registi		JAN 1 1 2		rar's Signatu	10	W -									
- C.		ch.	AUIS T T V	UU! Liestore	1	450										

DHMH 17 Rev 1/2001

			1 - For Registrar	State of Maryland		artment of H			giene 007	00486
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yea	
	/Medic Examin		Rose Marie 4a. Fecility Name (If not institution, give sti			4b. City, Town, or	r Location of Death	Januar	4c. County of De	
			Washington County			Hagers If Under 1 Year	town			ington
п	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1	7. Age (In yrs. Ia	a <i>st birthday)</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	v, Year)	Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent					June 1	2,1930 V	<u>Vashington</u>
	d within 72 hours after death with the Maryland jiene. I then "natural", or lieme 23a or 28a-1 ehow The Madical Examinar must be notified at	ō	MD Washingto		gerst(10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	Irect	10e. Street and Number)/i	901500	10f. Zip Code	-		10g. Citizen of What	
	23a o	alD	750 Dual Highway			2174	0		USA	
	ite de	une	11. Marital Status 12 Never Married 2 Married	. Was Decedent Ever in U.S Armed Forces?	5. 13.	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
9036	raf', or	by	3 □ Widowed 4 □ Rivorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		I ☐ Yes XIX No	Specify:		Specify:	White
15-0	"natu	Completed by Funeral Director	15. Decedent's Educa (Specify only highest grade of		(Give	lent's Usual Occupa	during most of work	ing	16b. Kind of Busines	ss/Industry
212	d within jiene. r then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired ory Worke	•		Grant Cab	inent Works
Maryland 21215-0036	be filed stal Hygie od other	Be	17. Father's Name (First, Middle, Last)		-1 40 60	y WOT KG			Maiden Sumame)	THERE NOT IVE
ryla	should be and Mental marked o	ဥ	Weltv Baker 19a. Informant's Name/Relationship (Type	Drint)	105 14-11	- Add (ChA		longan B		
	alith a		Tina Beatty (Da						r, City or Town, State gerstown	
Baltimore,	les 1 ar of Hea if item or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rer	20b. Pla	Annual Control of the	sition (Name of natory or other place		Date	20c. Location - City	
ţ	permit. Pages 1 Department of H Important: if ite eny injury or ot once.		4 Donation 5 ☐ Other (Specify)			Universi			Washingto	
Ba	Depa Impo eny ir	1 1)	21. Signature of Funeral Service Licensee Terry A Austin	200	38	321 14th	Street N	W Washi	ster Fune ngton D C	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	cause on each line.					rest,	Approximate Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	obstru	ctive Di	seone		34-690.
	Examiner		Sequentially list conditions b.							
35	ted nsit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dué to (or as a conseque	ence of).					
$\tilde{\lambda}_{r}$	execu on and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
8760Kg	icate be executed physicien and s the burial-transit	Cal	d							
9 X	certifica Iding pt	Physician/Med	IF FEMALE: 23c	. If yes, outcome of pregnan	cv					
. Box	es that the death certific igned by the ettending p be detached for use as	Iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Fetel of 4 Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
P. 0.	at the	Phys	9 □ Unknowń`	9□ Unknown						
ds,	igne bed	þ	Part II. Other significant conditions contri	buting to death but not resul	ting in the ur	derlying cause give	en in Part I.		4-	to the cause of death? Probably 4 □Unknown
Records,	law requir as been si 2 should i	plete						24a. Was a	n 24b. Were a	autopsy findings available
m m	ician: The lav certificete has rector, page 2	Completed						autops perform	v prior to	completion of cause of
Division of Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?	oital:		1000	26. Place of Death	Check only on	(0)	
ō	g Phys er this eral di	n: To	27. Manner of Death	1 Inpatient 2 E 28a. Date of Injury 2	R/Outpatient 28b. Time of	28c. Injury	at 2		ence 6 Other (Sp	ecify)
ion	stending death. ctor: Aft y the fun	atlo	1 ♠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? ∕es 2 □ No			
Σ Σ	i or Att efter de Directo I in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At hom building, etc. (Specify) 	ne, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
_	spitai	calCe	29a. Certifier 1 Certifying Physic	ian: To the best of my know	led e death	occurred at the time	e data and plana a	ind duals the or	tunafel modernmen at a	ic cluted
	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	P	(Check only 2 Medical Examine one)	 On the basis of examination and manner stated. 	on and/or inv	estigation, in my op	inion, death occurre	ed at the time, da	ate and place, and du	e to the cause(s)
	To To	Σ	29b. Signature and title of certifier	mal-		29c. License		2	9d. Date signed (Mor	, ,
	1	1	30. Name and address of poon who comp	bleted cause a death (Item 3	23a) (Tyne 1	Print)	\$365 It Heg		1-3-0	/
	Φ		19 ANZAR. 2:	SHALLY 36.	8 nu	il Stra	it Hou	revolor	m 190	21742
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 1 2007	3 Registrar's Signal	ye m	de la	(7.		
	negistr	-11	212 1 2001	1						

State of Maryland / Department of Health and Mental Hygiene 🗍 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Z:53 PM 200 Januar /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Care Cente Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1₩ 2□F Yrs 84 Director 213-18-1885 April 23,1922 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "naturel", or Items 23a or 28a-f show injury or other traumatic event, the Modical Examiner rust be notified at 1 ☐ Yes 2√√No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21219 United States 3230 Lynch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Maintenance Mechanical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ukn. Be Adam Stawski Ida 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau Villanova, PA 19085 Donna Wilson (Daughter) 220 Woodstock Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 1/8/2007 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. lea Cha 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 X No ischemia To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 28c. Injury at Work? After t 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of personano completed cause of death (Item 23a) (Type, Print) 5105 Hop king Vice 15021 Renoughill MD 55 Baltimore Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 8/8 AM oris 2007 anuarn 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hopkins Bauview Medical Center timore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🔀 F 404-54-4270 Virginia May 14,1941 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Dunda1k Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 241 St. Helena Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Government Telephone Operator 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Sexton Earl Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Colville 241 St. Helena Ave. (Companion) Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State tk☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 1/11/2007 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee Inc. 21222 Dundalk, Maryland 7922 Wise Ave. 20a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke disease or condition resulting in death) weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury Due to (or as a consequence of): Cause (Disease or injurthat initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year

Physician /Medical Examiner

permit. Pages 1 and 2. Department of Health a

Important: If item 27 any Injury or other to once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

þ

Completed

Be

၉

Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

V

5.1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene.
4 tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medicial Examiner must be notified at

Baltimore, Maryland 21215-0036

that the death certificate be executed

phys the L attending for ed by the a signed by t has page certificate

this

To the Hospital or Attending Pt within 24 hours atter death.
To the Funeral Director; After th completely filled in by the funeral

Division or Vital Records, P.O.

in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1∏ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

one	eck only	2 L IV	ledical
29b. Sigr	nature ar	d the of	certifier

du

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

RES-000 900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue, Bal 4940

32. Registrar's Signature

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

State Registrar

Eastern

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Stanley Clifford Silber 2007 8, 1845 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
July 19, 19 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F 294-09-4968 84 1922 Ohio Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2834 Aquarius Avenue 20906 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 [XYes 2 □ No
If Yes, Give
Year or Dates: 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Silber Gussie Boehm

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Funeral þ Completed permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If Item 27 Is marked other any injury or other traumatic event, tt

within 72 hours after death

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

certificate be executed burial-transit and attending physician for use as the buria the detached ate has been signed by page 2 should be detact certificate

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Examiner Physician/Medical þ Completed Be (Certification: To Medical

19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Addre	ss (Street and Numi	ber or Rural F	loute Number, Cit	y or Town, State,	Zip Code)
Charlotte G. Silber	/wife	2834 Aqua	rius Ave.	Silve	r Spring	, MD 209	06
20a. Method of Disposition 1 Burial 2 Acremation 3 Re 4 Donation 5 Other (Specify) 21. Signature 1 Funeral Service License	emoval from State Ch	Place of Disposition (Nemetery, crematory of esapeake Carrier States and Carrier Going	ame of rotherplace) rematory and Address of Faci Home Cre	Date 01/11 ility mation	/07 Be Service	Location - City o	r Town, State
23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deale cause on each line.	h. Do not enter the m	ode of dying, such a	is cardiac or r	espiratory arrest,	Laiksvii	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Scpsis Due to (or as a consec	uence of);					6 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutiv	uence of):					6 days
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknow						23d. Date of delivery Month Day Year	
Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part	i.			to the cause of death? Probably 4 □Unknown
				_	24a. Was an autopsy performed 1 Yes 2 △	? death?	autopsy findings available completion of cause of s 2 \sum No
25. Was case referred to medical examiner?				ce of Death (C	heck only one)		
1 ☐ Yes 2 🔀 No	ospital: 1 Inpatient 2 □	ER/Outpatient 3 🗆 🛭	OOA Other: 4 🗆 N	lursing Home	5 Residence	6 □Other (Sp	ecify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	off. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	lcian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date е оп, in my opinion, de	end place, and eath occurred	due to the cause at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier A		2	9c. License number		29d. [Date signed (Mor	oth Day Year)

State Registrar

Leo Shue, M.D. 9901 Medical Center Drive Rockville, MD 20850

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 1 1

160557

January 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anari itan 5 par in 880 8-22-07 ya State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Eleanor Marie Schoen 700G 10 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 12, 1916 N/A Hospital 000 Simonten 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 X F 90 Maryland Director Usuat Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits in than "natural", or items 23e or 28e-f show If a Modical Examinar trust be notified at 1√ Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5610 Plymouth Road 21214 United States Funeral 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married 1□Yes 2X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9 yrs. Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: if Item 27 is marked other tt any Injury or other traumatic event, Ita BARS. Pages 1 and 2 should be filed inent of Health and Mental Hygis int: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hoffmyer Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Henry H. Schoen / Husband 5610 Plymouth Rd. Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 01/08/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensea 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or comflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CUte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Severe andos the attending physicien and Due to (or as a consequence of): Physician/Medical Brangindia the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 PINO 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) To the Funeral Director: Alter th completely filled in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

Registrar
DHMH 17 Rev 1/2001

State

Setwan

5000

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

MUTPITE

32. Registrar's Signature

Estable of

5601 (Ach

07-00170 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Frederick August Smith State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg No. 1. Decedent's Name (First, Middle, Last) Physician/ Date of Death Medical Examiner 1840 hrs Frederick August Smi th January 6, 2007 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2911 White Avuene Baltimore N/A 5. Social Security Number If Under 1 Year 6 Sex 7 Age (In yrs. last birthday) If Under 24Hrs. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** Months Davs oreign Director Hours 220-30-0390 1 **X**M 71 July 18, 1935 2 Country) Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No Maryland N/A Baltimore after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2911 White Avenue 21214 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U S 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married X Yes White Yes, Give Year Ukn. 3 Widowed Divorced Yes 2 X No specify: Specify: Examiner "natural", ≥ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and 2 should be filed within 72 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical. 12 yrs. Mechanic Vending 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Roland Smi th Freda Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jeanette Opalensky/Sister 626 Cypress Point Dr. Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) Hilltop Service Corp. |01/13/2007 Towson, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 5305 Harford Road 1 Leonard J. Ruck, Inc. Baltimore, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If ves. outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Dav Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed^a death? Yes 2 V No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury Certification: ✓ Natural 5 Pending 1 Yes 2 No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) ms O.C.M.E. January 7, 2007

DHMH 17 Rev 1/2001

State Registrar

ORIĞINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Lina Li. MD

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Director: within 24 hours a To the Funeral I

27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa ure and title o

D18 768

1/08/2007

MARIO 31. Date filed (Month, Day, State

Medical

FRUZERGER 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

16 SOOPLEANS ST IMSI- BAYINA, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** ERRY 5°C AR DEAN 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DER CHESAPE 8. Date of Birth Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Year **Funeral** 1 M 2 □ F Months Min Days Hours Country) 505-56-9463 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Hes 2 No Health and Menital Hyglene. em 27 Is marked other than "natural", or Items 23a or 28a-f sh ther traumatic event, the Medic I Examiner must be notified Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 2100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 PYes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SA DISABLED 'à 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be NORA ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26.522 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other tra 00 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ cremation 4 □ Donation 5 □ Other (Specify) 21. Si r ature yr Funeral Service Licensee 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinct, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Ischemic Heart Physician uears /Medical Due to (or as a consequence of): Examiner 10 bacco Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed schemic 1∐ Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 📈 Inpatient Medical Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

nmoldt Terry mswyllyg Division or Vital Records, P.O. Box 68760, within 24 hours after www...

To the Funeral Director: After the Funeral Director of the funeral by the funeral properties of the funeral properties

State

13

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 1

1

29c. License number

29d. Date signed (Month, Day, Year)

		1 - For State Ragistrar	State of M	larylan		artment rtificate		ealth and N Death	_	giene Rag. No.	107	00494
Physicia /Medic	al	Decedent's Name (First, Middle, La Charles H. Scott A. Facility Name (If not institution, give	Jr.	1		4h City To	OWD Or	Location of Death	2. Date of De Month Jan.	Day 2	Year 2007 by of Death	3. Time of Death 2:00 P
Examin Funeral Director	er	Upper Chesapeake 5. Social Security Number 6. S	Hospital 7. A	-	last birthday Yrs.	F	alls Year		8. Date of Bir (Month, Da June 5	th	Harfo	place (State or Foreign ntry)
Maryland -1 show list at	tor	Usual Residence of Decedent 10a. State 10b. County MD Harford	l	10c. City	y, Town or L	ocation lair					1	10d. Inside City Limits 1 ☐ Yes 2 📉 No
death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 1809 Earl Dr.				10f. Zip C	210			10g. Citizen of	SA	
036 urs after el', or ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	? N o		1□ Yes 2 	₽ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Speci	ce - Americack, White,	
21215-003 de within 72 hours of whin 72 hours or then 'naturel',	Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or n/a	5+)	(Give	edent's Usual e kind of work DO NOT use nan - I	done di retired)	uring most of work	ing	16b. Kind of E		dustry
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If I lem 27 ie marked other then 'nature eny Injury or other treumstic event, the Marifical onde.	To Be C	17. Father's Name (First, Middle, Last Charles H. S 19a. Informant's Name/Relationship (cott, Sr.					18. Mother's Name	e Morge	, Maiden Suma nstern	me)	n Code)
nore, Ma nore, Ma ages 1 and 2 s ant of Health an at: if them 27 ter		Barbara LaPorta/ 20a. Method of Disposition MD Burial 2 Cremation 3 C	daughter	1 ^	1809		Dr.	, Belair				
Baltime Baltime permit. Pag Deperment: Important: eny Injury o		4 Donation 5 Other (Special Strature of Fusion Stra	s) Sincon		Le	2. Name and emmon F	Address	ral Home	of Dul	Kenil aney Va	11ev,	
nte be	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that cause	s a consequence of a co	uence of):	I W. PE	of dying	ia Rd., ', o, such as cardiac	l'imoniu:	m , MD 2	1093	Approximate Interval Between Onset and Death
SOUTED LESS Box 68 se that the death certification by the attending phose detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3	⊒Ectopic preg ⊒ Other (spec					ate of delive onth	ery Day Year
00 % E 8 8	þ	Part II. Other significant conditions of	contributing to death t	but not resu	ulting in the t	underlying cau	ise give	n in Part I.				ne causa of death?
2 s s s s s s s s s s s s s s s s s s s	e Completed	25. Was case referred to medical						26. Place of Deatl	1 Yes	osy rmed? 2,00 No	Were auto prior to cor death?	psy findings available impletion of cause of
on of oling Phys	Certification: To Be	examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending investigatio 3 Suicide 6 Could not b determined		ury ay Year) ijury - At ho	ER/Outpatie 28b. Time o Injury	of 280	Other C. Injury Work 1 Y	at ?	me 5 ☐ Resid 28d. Describe I	dence 6 □Otl now injury occu Street and Num	rred	y) Il Route Number.
Scott: Division of the Hospitel or Attention within 24 hours after dearf to the Funeral Directions completely filled in by the	Medical Cer	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner si	of my know	wledge, dea	th occurred at	the time	e, date and place, inion, death occurr	and due to the	cause(s) and m	anner as st	tated. the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier				D	56	number 54 5		/	ed (Month,	Day, Year)
Star Registra		30. Name and address of person who SHI WI KHOS (A) 31. Date filed (Month, Day, Year)		TZ 2'	#102	Print) BEL	_ A	IR, M)	2 210	214		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** January 6, 201 13:50 PM 4a. Facility Name (If not institution, give street and number) 6,2007 /Medical 4b. City, Town, or Location of Death **Examiner** Sinai Hospital of Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Co. 310, 1943 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 218.42.3578 Director VA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3021 Glen Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours aftereath and Mental Hygiene. n 27 is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Black Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 01500 5 Borber 5000 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Herman Ihompson Jenny Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cametery, crematory or other place)

Date hebecca A. Thompson , MD 21215 Itimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Memorial MCMorial 01.12.2007 Baltimore, Mi 22. Name and Address of Facility Vaughn Converne funeral 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Vaushn C. Green Pronunct strum 728 Liberty Thoud 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEPSIS 1eek /Medical Due to (or as a consequence of): **Examiner** Severe non-ischemic cardiomyopathy several years Sequentially list conditions, Completed by Physician/Medical Examiner if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown disease, pulmonary 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 211No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 6, and address of person who completed cause of death (Item 23a) (Type, Print)
Tha Ghash, MD Singi Hos of pital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Lee Tarver Jr. January 6 2007 "/Medical 03:48 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 0 3 0 7 Birthplace (State or Foreign Country) Months Year) X M 2□F 44 218-82-0193 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1√∑Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2518 West Lafayette Ave 21216 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: à Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2th grade Carpenter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee A. Tarver Sr. Yvonne Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Tarver-Wife 2518 West Lafayette Ave, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/11/07 Md Randallstown, 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signature of Funeral Service Licenses Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of Carcinoma pancrease with metastasis 1 month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or se a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 No Other: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗷 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be executed Ö σ. Division or Vital Records, Physician: or Attending s after death.

I Director: A
od in by the fu Hospital within 24 hours To the Funeral

Funeral

Director

show

r 28a-f shov notified at

"natural", or items 23a or

Medical

other than the

Pages 1 and 2 should be fill ment of Health and Mental H ant; If item 27 is marked oth

Baltimore,

Department of Heal important; if item 2 any injury or other once.

Physician

/Medical

Examiner

burial physician s the buria as

use

ō

signed by t

page certificate

funeral director,

filled

completely

Medical

State

Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

Karen M. Piper

31. Date filed (Month, Day, Year)

JAN 1

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N Charlesst

82. Registrar's Signature

After

death v

DHMH 17 Rev 1/2001

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sute 5218

29c. License number

00047223

29d. Date signed (Month, Day, Year)

1/6/2007

Baltimore mo

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:00 P M 2007 7, Tumine11o January Salvatore /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dulaney Towson Healthcare Center Towson If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 9, 1919

September 1919

September 1919

Louisiana 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1**∑**M 2□F Vrs Director 87 217-05-6672 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State or 28a-f ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner is ust be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Parkton 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21120 2 Quailwood Court Completed by Funeral filed within 72 hours after death 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 □ No Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Barber Grooming 06 n/a .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: if item 27 is marked other tigury or other traumatic event, iib 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown by informant ۵ unknown by informant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosemary C. DiVenti/Daughter 16302 Matthews Road, Monkton, Maryland 21111 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1/11/07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Dulaney Valley Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2 Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 21 ignatu Clary 10 W. Padonia Rd., Timonium, MD 21093 Bryan W. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that shock, of heart failure. List only one cause or each lin Onset and Death CARDIOVASCULAR Immediate Cause (Final disease or condition resulting in double) INTERIO SCUSIO TIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Ninknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 TYAS Division of Vital il or Attending Physician: after death. Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Cther: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28b. Time of Injury 28c. Injury at Work? 27. Magner of D ath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6717 Park Heights Ave., Balto., MD 21215 Howard Cohen, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 1 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 2007 Year Physician January 8, Gloria K. Tokosch 1:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Home for Hospice Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 250 1949 Maryland 215-54-1391 Vrs 57 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1XXes 2□No Maryland Director 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 21211 826 W. 33rd Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married _{Specif}White 1 ☐ Yes XX No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Accountant Door Mat Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hutchins Hazel Ballenger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aeron Tokosch Son 4709 Lavington Place, Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 1/10/2007 Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland m23a. Part1. Forter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** jaors /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death?
1 ☐ Yes 2 No 2□ No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the nospous after death.

To the Funeral Director: Af To the Hospital

30. Name and address of person who completed cause of dath (Item 23a) (Type, Print) N. Charles St. Balts. prd 2:200 Bin (31. Date filed (Month, Day, 32/Registrar's Signature State Registrar

and manner stated

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1- State Amend #2 Per DVR G8					Re	g. No. 2007	00499
	Physici		Decedent's Name (First, Middle, Last) JOHN WILLIAM THOMAS					2. Date of Death Month JANUARY	Day 2007 6, 2006	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and nu	ımber)	T	4b. City, Town, o	r Location of Deatl		4c. County of Deat	12:30pm
		t	717 DRUID PARK LAKE DE	. APT 61	0	BALTI	MORE		N/A	
-22	Funeral Director		5. Social Security Number 218-36-9764 Usual Residence of Decedent	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-15-	9. Birti 1941 MA	nplace (State or Foreign Intro) RYLAND
	yland now at		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Mar 8a-f sh tiffed	Director	MD, N/A	В	ALTIMO	ORE	_			Yes 2 No
	ath with the 23a or 23 ust be no		10e. Street and Number 717 DRUID PARK LAKE DR	. APT 61	0	10f. Zip Code 2121	.7	10	g. Citizen of What Co USA	untry?
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	Armed F	2 No ive X		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 XNo	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
15-(n 72 h ''natu edica	lete	15. Decedent's Education (Specify only highest grade completed)	A	16a. Deced	ent's Usual Occup kind of work done o O NOT use retired	ation during most of wor	king 1	6b. Kind of Business/I	ndustry
212	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		JTH COUNS			COUNSE	LING
pu	be filed ntal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	aiden Surname)	
Maryland	2 should be and Menta is marked aumatic ev	욘	LEO F. THOMAS 19a. Informant's Name/Relationship (Type, Print)		405 14-75-		VIOLA			
	nd 2 saith an 27 is i		LAWRANCE THOMAS (BROTHE	:R)					City or Town, State, Z	
altimore,	es 1 and 3 of Health f item 27 ir other tra	3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from	20b. Pla	ce of Dispos	sition (Name of natory or other place			Oc. Location - City or 1	
tim	Pages tment of tant: if it		4 □ Donation 5 ☑ Other (Specify)	MET:	RO CRI	EMATORY	1-10		BALTIMORE,	MARYLAND
Bal	permit. Pages Department of important: if if any injury or o	4	21. Signatur Ta Service Ligensee	The					L SERVICE MORE, MARY	LAND 21217
			23a. Part1. Enje the disease, or complications that shock, or leart failure. List only one cause on	aused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(or as a conseque	R +	A 17	ACI			Onset and Death
Į.	Examiner				ET	<u>د</u> ے				
	sit sit	iner	cause. Enter Underlying	(or as a conseque	nce of):					
	execut and ai-tran	Examiner	that initiated events	(or as a conseque	nce of):	4 F ZZ U	Rt			
68760,	rtificate be executed ig physician and as the burial-transit		d	C1201	LES	RESSU TENOL				
	ertifica ing ph e as th	Medical	IF FEMALE:							
P.O. Box	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant 1 Live I	tcome pf pregnand birth 2 □ Fetal d nant at time of dea own	leath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
ري ص	s that med by e deta	by Pr	Part II. Other significant conditions contributing to d	eath but not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sig should b	ted t	CHRONIC OBSTRU	CTIVE	Lu	NG	DISTAST	1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
Division or Vital Records,	Physician: The law r r this certificate has be ral director, page 2 sh	Completed						24a. Was an autopsy performe	ed? death?	opsy findings available impletion of cause of
Z.	sician certifi irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes ※ No Hospital: 1 ☐	leasting OFIE	2/0	20 DOA Othe		h (Check only one)		
0 (ding Phy h. After this funeral d	n: To	27. Manner of Death 28a. Date		8b. Time of	28c. Injury Work	4 LI Nursing He	ome 5 Residen 28d. Describe how	ce 6 Other (Speci	fy)
Sior	endin sath. or: Aft he fur	atio	2 Accident investigation	III, Day Year)	Injury		r res 2□No			
<u>Š</u>	tai or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build	of injury - At home ing, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the 2 ★ Medical Examiner: On the b and man	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as se e and place, and due t	stated. o the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier			29c. License	number	290	. Date signed (Month,	Day, Year)
	1	-	20 Name and address of a	and doubt the second	0-) (T	()	17511	2	1/ (6/	07
			30. Name and address of person who completed aus	ee of death (Item 23	142	Fu7A	10/(BACT	INORE M	1921217
	Sta Registr	9	I A L 1 1 2007	A Signatur	Acres 1	1				

DHMH 17 Rev 1/2001

Physician //Medical Examiner Julien VanBellinghen 4a. Facility Name (If not institution, give street and number) Chesapeake Future Care Arnold 5. Sevint Security Number 5. Sevint Security Number 15. Sevint Secur		9, 2007 4c. County of Deal Anne Arus	ndel thplace (State or Foreign
/Medical Examiner 4a. Facility Name (If not institution, give street and number) Chesapeake Future Care 5. Social Security Number 089-01-6113 4b. City, Town, or Location of Death Arnold Funeral Director Usual Residence of Decedent	3. Date of Birth (Month, Day, Jan 30),	4c. County of Dear	th ndel
Chesapeake Future Care Chesapeake Future Care Arnold Funeral Director O89-01-6113 Usual Residence of Decedent Arnold 7. Age (In yrs. last birthday) 91 Yrs. O91 Yrs. Arnold Wonths Days Hours Min. Usual Residence of Decedent	Jan 30,	Anne Aru	ndel thplace (State or Foreign
Director Oscillations of Decedent Director Usual Residence of Decedent	Jan 30,	Year) 9. Birl 1915 Belo	ountry)
To the state of th			
MD Anne Arundel Arnold Mode			10d. Inside City Limits
10e. Street and Number 10f. Zip Code 21012 10e. Street and Number 506 Norton Lane 11. Marital Status 1 Never Married 2 Marned 1 Never Married			1 Tes 2 No
506 Norton Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Narried 3 Widowed 4 Divorced 1 New or Dates: 42-45 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17 Set Pressman	rı	0g. Citizen of What Co	puntry?
11. Marital Status 1 Never Married 2 Married 1 Never		Inited Stat	ces
To the state of th	rfy Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: White	
(Specify only highest grade completed) College (1-4or 5+) College (1-4or 5+) Off Set Pressman		16b. Kind of Business	/industry
	F	Printing	
17. Father's Name (First, Middle, Last) 18. Mother's Name (Pierre VanBellinghen 18. Mother's Name (Mary Aline)		•	
The state of the s			Zip Code)
Jeanne Kayser / Daughter 506 Norton Lane Arnold, 1	an 16	20c. Location - City or Franklin S	
20a. Method of Disposition Donation Disposition Dis	an Char Annapol	oel lis, MD	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Physician Physician The disease or condition Physician	-		Approximate Interval Between Onset and Death Ueas
(Medical resulting in death) Due to (or as a consequence of):	,		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
edical E			
Solution by the past 12 months? IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	livery Day Year
E and I Part II. Other significant conditions contributing to death out not resulting in the ungertying cause given in Part I.		pacco use contribute to	o the cause of death?
a el el el el el el el el el el el el el	24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
25. Was case referred to madical examiner?	Check only one	θ/	
Thinpatient 2 Dervoupatient 3 DOA 42 Musing Home		ence 6 Other (Spe	ocify)
E a E E Marie di Dodati	8d. Describe ho	w injury occurred	
S = 2 Accident	Bf. Location (Str. City or Town	reet and Number or R r, State)	ural Route Number,
29a Cartiflier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
29b_Signature and title of ceptitier 29c. License number		9d. Date signed (Mon	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Senn ter Kied, nger 560/Veterans Hwy Mülle.	2	1-10-0	21100
State State Registrar State 31. Date filed (Month, Day, Year) 32. Destrar's Signature Registrar SAN 1 1 2007	rsvill	e, Mil	01108